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MENTAL HYGIENE

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MENTAL HEALTH AND ILLNESS*
THE NATIONAL PICTURE

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Medical Director, American Psychiatric Association

MENTAL Health Week is rapidly becoming a recognized institution throughout all the states. In many state capitals this week and next, citizens from every walk of life are expressing their interest in one of the most baffling of the health problems of the nation—the mental illnesses. This meeting is a tribute to the mental hygiene movement starting with Clifford Beers in 1908 and long nurtured by the National Committee for Mental Hygiene (now the National Association for Mental Health) and by Dr. George S. Stevenson, its leading spokesman for these many years.

All states have their ups and downs. Periods of intensive effort, with legislative and administrative backing, have given hope at times. Just now, we find great hope in the renewed life and vigor that present leaders are imparting to the state program. In Pennsylvania, for example, backed by his Excellency the Governor, the Secretary of Welfare, the Honorable Harry Shapiro, is launching a new effort which, judging from the start that has been made, will give the mentally ill in Pennsylvania markedly improved status. With the help of the newly formed advisory committee, it appears that political and professional leadership and support are available and will be ingeniously applied. The legislature has from time to time appropriated increased funds, and I am told that the sum of money available for operation of mental institutions has been tripled — going from $30,000,000 in 1944 to nearly $90,000,000 at this time.

Yet, in spite of some splendid new buildings here and there,

* Address presented at the Mental Health Week rally held in Harrisburg, Pa., April 28, 1955, by Pennsylvania Mental Health, Inc.

there are still overcrowding, shortage of staff, low discharge rates, and failure to keep up with the pressure of new admissions. Statistically, the size of the problem has not diminished since 1944, though I am sure there are some qualitative gains. Thus, if increased expenditures have essentially failed to make a real dent on the problem, it remains to discover just what has been missing in the development of the program over the last ten years, and this I am sure can be done. But first, let's look at the national picture.

"Some 750,000 mentally ill and retarded patients are now being hospitalized on any given day.

"Forty-seven percent of the hospital beds in the nation are occupied by mental patients.

"The direct economic cost of mental illness to the taxpayers of the nation, including pensions to veterans with psychiatric disabilities, is over $1,000,000,000 a year and has been increasing at the rate of $100,000,000 a year.

"The emotional impact and distress suffered by millions of our people anxiously and justifiably concerned about the welfare, treatment, and prospects of mentally afflicted relatives is incalculable and is one of the most urgent concerns of our people.

"The governors of the several states, through national and regional governors' conferences and through the publications of the Council of State Governments, have shown great initiative in their cooperative attempts to develop better methods of meeting the challenge of mental illness in their states.

"There is strong justification for believing that this constantly growing burden may well be due primarily to an outmoded reliance on simple custodial care in mental hospitals as the chief method of dealing with mental illness.

"There is strong reason to believe that lack of early intensive treatment facilities has created such a backlog of mentally deteriorated patients that it has become virtually impossible for the states to meet the need for mental hospital facilities.

"There is strong reason to believe that one of the greatest impediments to more rapid progress in the field of mental health is a definite shortage of professional personnel in all categories.

"There seems to be a discouraging lag between the discovery of new knowledge and skills in treating mental illness

and their widespread application, as is evidenced by the fact that whereas only about one-third of newly admitted mental patients are discharged from state hospitals in the course of a year, in a few outstanding institutions the recovery rate is 75 percent or more.

"Experience with certain community out-patient clinics and rehabilitation centers would seem to indicate that many mental patients could be better treated on an out-patient basis at much lower cost than by a hospital.

"There is strong reason to believe that a substantial proportion of public mental hospital facilities are being utilized for the care of elderly persons who could be better cared for and receive better treatment in modified facilities at lower cost" (provided these simplified housing arrangements are under proper administrative and professional control).

"There is reason to believe that many emotionally disturbed children are being placed in mental hospitals, which have no proper facilities to administer to their needs.

"Mental illness is frequently a component of such nationwide problems as alcoholism, drug addiction, juvenile delinquency, broken homes, school failures, absenteeism and job maladjustment in industry, suicide, and similar problems.

"There seems to be no overall integrated body of knowledge concerning all aspects of the present status of our resources, methods, and practices for diagnosing, treating, caring for, and rehabilitating the mentally ill, although only through the development of such a body of knowledge can the people of the United States ascertain the true nature of this staggering problem and develop more effective plans to meet it.

"By supporting enormous capital investment in new mental hospital construction, the American people have demonstrated their growing understanding of the economic and social cost of mental illness, and their willingness to sacrifice to overcome it."

It may be surprising to state that all of the above statements are quoted from a legislative proposal now (1955) before Congress. This proposal (Joint Resolution 256), in which we all have a stake, would make funds available for a national study of all aspects of our present methods and practices for diagnosing, caring for, and rehabilitating the mentally ill. It

has already passed the House of Representatives and may pass the Senate any day now.*

It was Dr. Kenneth E. Appel who first conceived and formulated the idea of the need for such a national study about two years ago when he was president of the American Psychiatric Association. In his own words, Dr. Appel has stated:

> Planning on a nationwide, long-term scale is essential. A commission should be established to study current conditions and develop a national mental health program. Patchwork, stop-gap programs are keeping us on a treadmill and actually doing little or nothing to reduce and prevent mental illness. We resign ourselves to needless suffering and to the waste of money and human resources, instead of taking action. Mental illness is not a parochial problem. It must be attacked on a national scale. Psychiatrists should be leaders in this attack. We can contribute much in experience and insights. We should enlist the collaboration of all other professional groups that are concerned with the medical and social aspects of mental illness and mental health.

Now Dr. Appel's original conception has become the common property of all of us to whom this national problem has been of such deep concern these many years past.

The happy fact of the matter is that we are in the midst of an unprecedented national concern and determination to do something about the massive problem of mental illnesses. The governors have made their concern crystal clear in their national and regional conferences. In the Congress, the joint resolution I mentioned was sponsored by 42 senators from both political parties. Legislatures by the score throughout the 48 states are falling in with the new spirit that something can and must be done about this great problem beyond providing minimal custodial care for the mentally ill, and in many states (though not all) the legislators have already substantially increased their appropriations for mental health.

Popular radio and television stars are coming to us asking how they can help. One of our famous baseball players, in one of our great popular magazines, has told how he had been taken mentally ill, hospitalized, and recovered. The famed Dr. Jonas Salk and his associates have pegged mental illness as the next great medical problem (after polio) that should occupy our national attention.

* Joint Resolution 256 became Public Law 182 of the 84th Congress on July 28, 1955, when it was signed by President Eisenhower after passing both houses of Congress without a dissenting vote.

So I say we are on the threshold of a new era in our struggle to cope with this great problem. And it is particularly pertinent at this time to let Shakespeare remind us that "there is a tide in the affairs of men, which, taken at the flood, leads on to fortune," for there seems every likelihood that in the climate of good will in which we now find ourselves we may discover the wherewithal to launch a far more fundamental attack on mental illness than has ever before been feasible.

What is to be done? In what direction should we go? Our first thoughts, of course, must focus on the patients in the hospitals. By way of dramatic emphasis, I might point out that at the moment there are plans in eight states that I know of to spend $950,000,000 for new construction of mental hospital facilities, and this in spite of the fact that in no instance are any existing public hospitals sufficiently staffed to take full advantage of the relatively meager knowledge we now have.

Nevertheless, there are many encouraging things and some rather astounding successes in our hospitals which most of us know little about. Two or three of the illnesses related to brain damage have been essentially conquered, such as general paresis, which at one time accounted for ten percent or more of our patients. Outside of our hospitals, few people realize the tremendous increase of activity potential in those states which used to be ridden by hookworm disease and which are now relatively free of it. This is the disease which caused so much apathy, weariness, lack of initiative, and frequently a complete destruction of motivation to succeed in life, to take care of one's family, to make anything out of life.

Now also we have come to understand the role vitamins play in pellagra, which has so often masqueraded as "senile psychosis" in our mental hospitals.

In another group of patients, which might almost be said to include at least one in every family, we find the so-called "middle-age reaction," which in its extreme form is known as involutional melancolia. Now the treatment of this disease is almost as successful as penicillin has been for pneumonia. Except in cases where there is a serious overlay of other conditions, the patient with middle-age depression, who used to take two to three years to treat under the best of conditions,

now frequently leaves the hospital in two or three weeks. A member of my own family was cured in eleven days.

Another most remarkable thing is that an ever greater number of patients with serious mental illness are now being taken care of in out-patient clinics, and often they continue to assume responsibility in the family and on the job while they are undergoing treatment. In other words, hospitalization for many of the seriously ill is frequently unnecessary. I suggest that *this factor of what can be accomplished outside the mental hospital is the most important single thing we should study and carry to its utmost logical conclusion.* When community services are available, many patients can be kept out of hospitals. Many patients can get out of hospitals far sooner than they otherwise could. And many of those who come out need never return to the hospital again.

I want to describe briefly a general concept of an overall community approach to the mental illness problem which is understood quite widely abroad but has not as yet been introduced to any substantial extent in the United States. I refer to the concept of the "mental health community center."

The mental health center was described and carefully worked out by representatives of ten nations, from all continents, at a meeting of the World Health Organization in 1952 in Geneva, Switzerland. I found later on that an article on the same general subject had been published in the *New York Times* by Dr. George S. Stevenson, of the National Committee for Mental Hygiene, in 1948.

A mental health center can be adapted to the needs of any community or region of a state. In effect, it is an organization under responsible leadership, designed to unite the resources of the state program with the efforts of private practitioners in the community, including the various specialties, professional people in the school system, industry, the public health department (particularly public health nurses), social agencies, etc.

Let me try to paint a picture of how such a center is operating in one place in England. There is only one in England—and it is there not because of the special medical plan there but because of the leadership of one individual, Dr. T. P. Rees, who is unique in his imagination, his organizing ability,

his feeling of public service, and in his faith in mental patients and in their relatives.

There is a mental hospital nearby, but Dr. Rees spends a good deal of his time as director of the Mental Health Center. This includes an out-patient clinic to take care of those living at home. He had a group of doctors, nurses, social workers, and others, some of whom work in the mental hospital part of the time but who are rotated through the mental health center to give part of their time to the community service. Dr. Rees works with a group of specialists in psychiatry who are doing private practice and makes use of their services, part-time in the clinic and part-time as private practitioners. He hears about people becoming ill and sends a team into the home to see what they need and to assist in finding out the *simplest* form of service that would take care of them. (What a contrast is this to what we usually do! As soon as someone becomes ill, our first step is to send him immediately to a mental hospital.) Some of Dr. Rees' staff also rotate in looking after the psychiatric unit of a general hospital nearby.

In this mental health center there are clubs for people who have been mental hospital patients but who are now living at home and can come in for social life. A good deal of group therapy goes on in the main building of the center. A number of older people who are not sick or broken down come in for various activities, occupational therapy work, and general preventive services which help keep them on their feet and in circulation. A number of crippled people of various types also come there to participate in various activities to see how life can be made more useful to them. A well-baby clinic and a child guidance clinic are available for both children and parents.

In general, there is an *organized pulling together* of all the resources in the community, to the total effect that a population of 250,000 people is easily taken care of in a community where the hospital alone has only 1,000 beds. And these 1,000 beds are largely for patients who have been there for many years and who did not have the advantages of early treatment through the mental hospital center. The newly sick patients are mostly taken care of in the community itself.

The experience of Dr. Rees suggests in a dramatic way

that the ideal community must make available a network of services to deal efficiently with its mental health and illness problems, as exemplified by this mental health center. The essential ingredients are *home care, private individual attention, visiting nurses, teams to visit those who cannot be reached by general practitioners, psychiatric units in a general hospital, out-patient services for children and their parents,* and in the background a *regular mental hospital* for the limited number of patients who cannot be cared for at home and who may be sent to the hospital for a short time.

The implication of all this is that in looking to the future we need to de-emphasize our traditional reliance on the mental hospital as an almost exclusive tool for dealing with the mentally ill, and rather think of it as merely one part of a network of community services, all of them designed to forestall hospitalization if possible, and, if not, to make duration of stay in the hospital as short as possible.

I wonder to what extent we appreciate the thought that services in the community are equally valuable to the services of hospitals. The Commissioner of Mental Hygiene of a great state was present when I was making some remarks like these before his advisory council and he said, "We have been doing that for a long time." I said, "Do you really believe community services are as important as hospital services?" "Certainly we do," he assured me. "Well," I said, "would you approve of doubling the budget of your hospitals and spending an equal amount in the communities? Would you put $140,000,000 into community services? Because that's what you're spending now in hospitalization with little effect." That was a rather staggering suggestion, but that state has only this year put $15,000,000 into community services. What would Pennsylvania think of putting $90,000,000 into the budget for hospitals and an additional $90,000,000 for community services? That amount—$90,000,000—can be eaten up overnight in operating buildings which, without staffs, can get nowhere so far as reducing the number of patients is concerned. Is it so fantastic and unrealistic to suggest that the same amount of money invested in the kind of community services I have spoken of would pay much greater dividends in the long run?

In one state where I was recently a consultant in making a

survey of its mental health resources and needs, we found that there was apparently no recourse except to build another $35,000,000 hospital. Yet the survey committee, at my urging, recommended delaying it for the time being and recommended putting an additional $3,000,000 a year at the disposal of the Department of Mental Hygiene to create community services —in fact, to create one mental health center, as I described it above, and see whether or not it would be possible to avoid the building of a $35,000,000 institution. With this money, the department could study the problem of personnel, create large sums for research, finance many out-patient clinical services, and give money to the universities, the schools of nursing, the departments of psychology, the departments of medicine, and the schools of social work and occupational therapy to increase their staffs and take over responsibility for training in all the state institutions.

There are many things one can do with money. It is easy to get it for buildings; it is very hard to get it for anything else. What I suggest is that more money be spent on experimental and pilot projects with adjunctive and modified types of hospital and community facilities which may be demonstrated to be effective in forestalling, preventing, or shortening hospitalization. Such facilities are variously called branch hospitals for the aged, day hospitals, night hospitals, halfway houses, mental health centers, rehabilitation centers, and the like. They are essentially modifications and expansion of the mental health clinic idea. Experimentation with these types of facilities has been going on in a few places, chiefly outside the United States, with some indication of success. They represent new and promising approaches.

Let me say also that there is no doubt in my mind that through administrative experimentation we can discover ways of using our present personnel more efficiently. It is my observation in my travels that highly trained key personnel in the hospitals are performing functions and duties which they would like to delegate to less highly trained personnel if a method for doing so could be worked out. There is a tendency to confuse the rôle of top-level leadership on the one hand with operational and technical performance on the other. Hospital administration is hampered by traditional and rigid

conceptions of personnel policies. I am certain that administrative experimentation will show ways of breaking through these barriers, thereby releasing more personnel time for the benefit of the patients.

What are the practical steps that should be undertaken at this time? I can suggest one or two. The first is amplifying and refining the information now in existence—and I would say that a good deal of data in a sketchy sort of way is available in the states. A number of very good studies have been made lately, but they do not go far enough. The American Psychiatric Association has recently been invited by a number of states to come in and assist them in making a comprehensive survey of their total needs and total resources for dealing with mental illness and health. Our survey technique considers 13 different categories of approach to the problems, of which the mental hospitals are only one. Due attention is paid to the relative rôles and responsibilities of federal, state, county, and city authorities as well as private organizations and professional people in private practice.

Indeed, in our state survey work we have to some extent outlined an approach which should be useful as a precedent for the national survey now contemplated under Congressional legislation. A basic assumption underlying the national survey is that out of it will evolve some fundamental new departures from our traditional concepts and methods of dealing with mental illness and that it will lead to a far more effective attack on the problem than has thus far been realized. There is crying need to reexamine our basic assumptions in the field; to see what actually takes place in hospitals with high discharge rates as compared to others with low discharge rates; to assess the factors which account for the tragic lag between the development of psychiatric knowledge and its application in public mental hospitals; to determine the extent to which community services pay off in keeping people out of mental hospitals; to discover the most effective ways of utilizing present personnel; to find out more about the epidemiology of mental illness; to discover why it is that young professional students resist entering the field of mental illness; to find out exactly what our personnel needs are; to review our whole statistical system for gathering data on mental illness; to assess the contribution psychiatry can make to the various

social ills in which mental illness is a component, such as alcoholism, drug addiction, juvenile delinquency and crime, broken homes, school failures, misfits in industry, accident proneness on the highway, suicides, and so on.

But, of course, the findings of the national survey will not be available for the next three or four years, and in the meantime it is important for the several states to push ahead with their own programs and to capitalize to the utmost on prevailing public enthusiasm and good will to get things done.

Perhaps the greatest single need, from the standpoint of organization, would be for the state Mental Health Associations, assisted by other citizens groups, to proceed as fast as possible to organize effectively in various communities and counties, so that their fund-raising campaign may be worked out in detail and carried out with the greatest possible dispatch. How are we going to appeal to people to give us money? How can we convince people that their gifts will have real meaning and benefit for *their* communities?

Certainly you can ask for money for research, for this money can be used wherever research people are available, and there are plenty of such people who can carry out not only basic research but also a broader type of research involving various types of community studies.

You can raise money for community clinical services. I believe it is possible to sell people in every state on the need for services, or child guidance clinics, or a referral center, or a screening facility in their area. It is true that manpower is short. But it is also true that there are many people available on a part-time basis and that a small amount of work started locally usually increases the number of people available as time goes on. I was struck by what happened in Kentucky, where we are now making a survey. In one remote place the only person interested in this entire field — in the absence of any local mental hygiene organization — was a part-time psychologist assigned by the State Department of Mental Hygiene to western Kentucky. He was able to visit this particular town only on rare occasions. Nevertheless, his influence was soon felt and he got the community to discussing and thinking about their local needs. A great deal has since

come out of the very small bit of clinical services which he could personally provide.

I think also you can appeal to people to give money to set up administrative offices in different localities with part-time or full-time executive officers whose business is to get around and study the community's needs and put the people who need help in touch with those who can do something for them, even though they may have to be referred to a distant hospital. This person could organize the interest of people and carry on a continuous effort to work with the medical profession and the nursing group, with people in the courts, in the schools and colleges, and in industry and labor. Such might be the beginning step in the development of a mental health center.

No one knows better than I that fund-raising in this field is a difficult proposition, and the job is not made easier because we deal with a field which has always been mysterious and frightening to the layman. As we survey the tremendous job to be done and the intricate pattern of life into which new-born babies, children, adolescents, and adults now have to live, the tremendous burden of hospitalization to the taxpayer, the lack of scientific data about some of our major mental illnesses, the great stumbling block of personnel shortages, and the like, it is hard not to get discouraged.

I would like to quote a friend we all know, Dr. Alan Gregg of the Rockefeller Foundation, from a speech he made in London in 1948 at the first meeting of the World Federation for Mental Health:

> At the dedication of the 200-inch telescope on Mount Palomer in 1948 the guests were allowed to look at a star never seen by man before—a star whose light has been on its swift way hither at 186,000 miles a second for 195,000,000 years—a star which could not receive today's sunlight until the year 195,001,948, A.D. One of the speakers on this occasion, Raymond Fosdick, was tempted to recall the story of the little girl whose version of the nursery rhyme was "Twinkle, twinkle, little star, how you wonder what I are!" The perspective of human life and individual importance in such a matrix of space and time might make us wince. But Mr. Fosdick reminded his audience that although the philosopher may say, "Astronomically speaking, man is completely negligible," the psychologist can reply, "Astronomically speaking, man is the astronomer." And in that heartening answer lie the consolation and the glory of those who study the mind and spirit of man.

STATES ASTIR AGAINST MENTAL DISEASE*

ALBERT DEUTSCH

I HAVE been witness to many changes in the mental health movement since I entered it through the back door of history exactly twenty years ago, when the late Clifford W. Beers generously got me a grant that made possible the preparation of my history of the care and treatment of the mentally ill in America. Since then, as social historian and journalist, I have made the rounds of more than sixty mental hospitals and numerous mental clinics, together with many centers of psychiatric research and training. Having surveyed the field vertically and horizontally, and having noted periods of inspiring progress alternating with heartbreaking retrogression, I now feel no hesitation in predicting that, barring man-made cataclysms, the next decade or two will see more advances in the war against mental disease than were registered in any previous century.

The signs are here. New warrants for optimism spring up in unexpected places. Among the most encouraging is the emergence of "practical politicians" as leaders in state mental health programs. For many decades, even before the organized mental health movement got under way, the declarations of so-called reformers that cut-rate custodial care for the mentally ill was not only inhumane but uneconomic were met by derision and cynicism on the part of the practical politicians. But today we witness multiplying signs that the practical politicians are heeding this truth, so tragically ignored heretofore.

They are sobered by such demonstrated facts as these:

Penny-pinching on mental hospital budgets, depriving large numbers of patients from an opportunity for speedy recovery and thereby dooming them to long-time institutional confinement, actually drains increasingly huge parts of the public budget—as much as one-fourth and even one-third of the total budget in some states.

* Keynote address presented at the Annual Meeting of the National Association for Mental Health, held October 23, 1954, in New York City.

Over 650,000 Americans are now resident in our public mental hospitals, and new patients are being admitted at the rate of 200,000 every year. (Think of it! Within the next five years one million Americans will become mental hospital patients for the first time, and more than half a million ex-patients will return to these hospitals as relapsed cases.)

The cost of maintaining the mentally ill now runs to one billion public tax dollars, and is mounting steadily as untreated and ill-treated cases accumulate in our institutions.

More and more practical politicians are reacting intelligently to such facts and figures, spurred on by the mental health movement. The Council of State Governments, representing the governors of all 48 states, has done extraordinary work in organizing governors' conferences on mental health, bringing the problem to the attention of politicians as a primary one for state executives, conducting mental health surveys and publishing outstanding reports, and urging concrete recommendations for adoption by the several states.

Incidentally, I've been disappointed, in my journalistic rounds, by the number of state mental health societies that have failed to utilize the findings and recommendations of the Council of State Governments, based on its own sound surveys of psychiatric hospitals, training, and research. The officially approved programs could provide very effective ammunition for state and local mental health campaigns. The recent Council-sponsored Governors' Conference on Mental Health has strongly urged that all state legislatures make considerable increases in mental hospital appropriations, most especially for expanded research and training programs. Mental health groups would do well to familiarize themselves with the 10-point program adopted by the Governors' Conference in 1954, for application in their own areas.

Under the stimulus of the Council, directed by Frank Bane, an increasing number of state governments are participating in regional conferences for cooperative mental health programs. Only a few months ago, ten midwestern state governments were represented at such a conference. The Southern Regional Education Board, representing 16 state governments, has already stimulated progressive programs for psychiatric treatment, research and training in the South.

The New York State Legislature of 1954 blazed a new trail—as significant as the pioneer State Care Act adopted 60 years ago by the same body—when it passed without a single dissenting vote the Community Mental Health Services Act. This statute provides for a 50 percent state financial share in such locally operated facilities as child guidance and community clinics, psychiatric wards in general hospitals, rehabilitation programs, and psychiatric consultative services to schools, health and welfare agencies, and the like. This development bids fair to break the serious financial bottleneck to the expansion of local services that can check effectively the increasing flow of men, women and children to our state hospitals, with attending heartbreak and wasteful expenditures. Also notable in 1954 was the overwhelming approval by both the legislature and general citizenry of New York of a $350,000,000 bond issue for expanded and improved state mental health facilities.

The California State Mental Hygiene Department drafted a community mental health services program very similar to the one adopted in New York, which will be re-submitted to the next California Legislature, after being narrowly defeated in the 1955 session. Similar progress reports are received from state after state. Indiana, until recently one of the most benighted states in the mental health realm, is experiencing an impressive resurgence under the leadership of Dr. Margaret Morgan, the state mental health commissioner, actively supported by Governor Craig. The lowly bedlams of Kansas are being converted into first-class state mental institutions, thanks mainly to the untiring, dynamic stimulation of the Menningers of Topeka. Anyone who, like myself, went through the appalling bedlam that was the Topeka State Hospital a decade ago and has visited the same institution recently must feel as if he were witnessing a modern miracle. I recall a similar experience several years ago when I made a tour of Minnesota state hospitals with Governor Luther Youngdahl, now a federal judge, who had assumed the rôle of the leading crusader for modern psychiatric care and treatment in his state.

And so we witness, in state after state, the paradoxical spectacle in which hard-headed politicians, traditionally the

foes of mental health "reformers," take leadership in the very "reform" movement formerly despised as idealistic and impractical.

This heartening development in some states should not blind us, however, to the persisting evil of unwholesome political control in others. It is shameful to see, in our time, the continued use in many states of mental hospital systems as patronage mills for partisan politics, with wholesale ousters of personnel, from commissioners down to attendants, with every change in party control of the state machinery.

The mental health movement in America, in spite of chronic financial difficulties, has shown renewed vigor in recent years, especially since the great reorganization of the National Association for Mental Health. But it still suffers sadly from lack of clear direction and stable leadership. In my journeyings around the country I am heartened by the resurgence of organized mental health in some states, disappointed by the tendency in others to substitute glittering generalities about "positive mental health" while ignoring or understressing desperate needs of a concrete nature for which known correctives and solutions are at hand. I am particularly concerned with the tendency, in some mental health societies, to adopt a do-little attitude toward disgraceful and remediable conditions in most of our public mental hospitals. They expend their zeal rather in promoting ambiguous and often fleeting concepts about "mental health," along with confusing and mutually contradictory theories unsupported by solid scientific knowledge. There is a corollary tendency to concentrate on theoretical lectures for relatively small groups already sold on mental health while neglecting the task of developing mass support behind the application of tried techniques and procedures in the treatment of those who are already the victims of mental disease.

I do not mean to minimize the great importance of a search for a positive mental health program. My reference to "glittering generalities" applies to the trite homilies and slogans presented in the name of mental health, and also to the disposition to repeat glibly and endlessly the term "mental health" as though it had an intrinsic magic power like unto the mystic words on prayer-wheels. We have a growing body of knowledge about mental health techniques in certain areas of

life, and they are being put to use effectively in some places. Such programs should be pushed, but not at the price of neglecting the mentally sick.

I see, in too many states, a virtual abandonment of mental hospital patients by societies especially entrusted with the task of mobilizing public support for improved institutional conditions. Too many of us tend to forget that the mental health movement was founded by an ex-mental patient as a result of his own harrowing institutional experiences and observations. It remains a capital irony that the traditional neglect of hospitalized mental patients is too often supplemented by neglect on the part of groups supposedly dedicated to better care and treatment. Would that our mental hospital conditions were improved to such a degree that we could concentrate on the greater, though more distant, goals of educating the public in principles of mental health. Alas, this is not the case.

On this score, while proudly pointing to dramatic institutional advances in recent years, let us not forget that this progress is relative and that it stems from an appallingly low point of a decade ago, when many of our mental hospitals were not entitled to be called treatment places or even asylums in the real sense; when most of them showed the tragic evidence of accumulated decades of neglect, financial impoverishment, public apathy, legislative penury, and administrative despair; when, as an outstanding expert, Dr. Kenneth Appel, last year's president of the American Psychiatric Association, summed up the situation pithily:

"Conditions in our public mental hospitals are shocking, monstrous, and horrible. The majority of hospitals do not give treatment. They give custody—poor at that. Patients are herded like sheep. Automobiles get better attention than most mental patients today. The grass surrounding the state hospitals receives more care and consideration than the patients inside."

That terribly true indictment was uttered only a decade ago. When we record encouraging recent advances, we cannot ignore the sobering fact that after surveying most of our state mental hospitals the American Psychiatric Association's central inspection board could give its full approval to less than three percent of the surveyed institutions, and could give

conditional approval to less than 17 percent more. That leaves four out of every five state mental hospitals still on the unapproved list—a sorry record.

On the administrative side of the mental health picture, the two-year survey conducted by Raymond Fuller for the National Association for Mental Health (the findings of which were published in 1954) revealed the jumbled, anarchic state of governmental organization found in most states. As Mr. Fuller disclosed: "... while the task of state care and treatment has changed, the administrative means and mechanisms for performing it have not changed correspondingly. The tools provided for administration, the setups and systems of most states, remain archaic and inadequate, ill-fitted to the job to be done."

We still have far too many mental hospitals operated on a custodial rather than a therapeutic basis, where patients are deprived of the basic right to receive the benefits of modern psychiatric knowledge that might restore them to sanity. Three-fourths of our state mental hospitals still suffer from overcrowding—a condition that means far more than mere physical discomfort; it creates a chain of corollary conditions that effectively reduce the chances of recovery and even aggravate the disease in many patients. Nearly all our mental hospitals are still grossly understaffed. In too many hospital wards one still sees a shocking proportion of patients in straitjackets, straps, and other mechanical restraints—barbaric vestiges that have been banished from our well conducted institutions. In too many wards one still sees evidence of grossly excessive sedation—at times adding drug addiction to the other burdens of mental patients. In too many hospitals increased per capita expenditures have barely kept pace with monetary inflation, giving a false sense of increase while failing to guarantee even minimum subsistence levels, let alone active therapy.

In too many states and communities persons who experience a mental breakdown at home are still removed by policemen untrained in humane and efficient handling of such patients. They are too often transported to lockups or jails in patrol wagons, rather than to hospitals in ambulances. Recently I received a letter from an ex-patient, now recovered, the wife of a college instructor, who lavished praise on the fine treat-

ment she had received in a public mental hospital but who has not gotten over the shock of the brutal handling she was subjected to by the police and jail keepers to whom she was entrusted before her commitment.

The quasi-criminal handling of mentally sick people pending commitment or other disposition persists in intolerable forms in too many communities boasting of civilized status. In this particular aspect, too, I find too many mental health societies so busily engaged in the dissemination of trite generalities that they overlook outrageous practices and procedures right at their own doorsteps.

In short, there is far too much tolerance of evils, abuses, and neglects in a society that boasts such great wealth and culture, too much acceptance of snake-pit levels in the handling of the mentally sick. I do not urge a reduction of activity on the preventive side of mental health; I do plead for greater attention to the plight of the more than half a million fellow-humans in our overcrowded, understaffed mental hospitals—the victims of mental disease who rate a priority on our attention.

In spite of the foregoing catalog of continuing defects, I cling more firmly than ever to an optimistic view of the immediate and ultimate future of the mental health movement. Compared to the tempo of evolution in former times, the developments of the past decade or two have been stupendous. Besides the enlistment of many powerful practical politicians in our ranks, we can regard with much satisfaction the inroads made against centuries-old myths about mental disease—such as the misconceptions that mental disease is a disgrace or a sin, that it is almost always hereditary, that it is never curable, and that it is typically manifested by violently dangerous behavior.

The American Psychiatric Association, during the last decade, has responded to the calls on professional responsibility by inaugurating many programs aimed at improving psychiatric standards through its mental hospital inspection and rating service, its annual mental hospital institutes, its special surveys, and its public education programs.

The American Medical Association, long neglectful of the general physicians' responsibilities in the mental health field, has established recently a committee on mental health, under

the able leadership of Dr. Leo Bartemeier, that promises to make significant contributions to greater medical and lay understanding of the mental disease problem.

The small but effective National Mental Health Committee, centered in the nation's capital, has done an impressive job in stimulating Congress and state legislatures to expand governmental support of psychiatric research and training.

The establishment of the National Institute of Mental Health within the U. S. Public Health Service in 1946 marked a milestone in the development of research and training resources, so desperately needed today. The transformation during the past decade of the Veterans Administration psychiatric facilities from the scorned "backwaters of American medicine" to first-rate therapeutic centers is little less than a miracle.

On the international scene, the slow but steady development of the World Federation for Mental Health since its founding six years ago as a clearing-house for information and activities is bringing dividends to the United States, along with other countries. Similarly with the mental health section of the World Health Organization, established about the same time.

In a thousand medical laboratories, psychiatric clinics, and hospitals, research into the causes, treatments, and possible methods of prevention of mental disease is piling up a steady accumulation of psychiatric knowledge that is bound to produce great, perhaps undreamed-of, discoveries in the not distant future. It is already heartening to be told by conservative psychiatrists that schizophrenia, not long ago widely considered a hopeless psychosis, can be treated successfully with modern therapies in from 40 to 60 percent of the cases. It is likewise heartening to be told that the recovery rate in involutional melancholia, another major psychosis, has been doubled in the last 20 years.

Help has come from non-psychiatric sources in the prevention and treatment of such psychiatric ailments as general paresis—syphilis of the central nervous system—which once accounted for more than one-tenth of the total mental hospital population and is now virtually disappearing, thanks to the discovery and application of penicillin. The same is true of the discovery of a simple vitamin treatment for pellagra,

which once contributed heavily to the patient load in a number of southern mental hospitals.

An increasing number of research centers are contributing valuable clues to the understanding and treatment of child behavior problems and of the mental disabilities of old age. The latter is of prime importance, since the so-called senile psychoses account today for the greatest proportion of mental hospital admissions.

In one psychiatric area after another, bright beams of optimism dispel the long shadows of despair. The acceleration of the war against mental illness offers people of good will everywhere one of the most vital medical and social challenges of our time. We in the mental health movement can enlist larger armies of recruits into this war and wage it more effectively if we:

Bring into sharper focus our immediate and long-term goals.

Substitute specific programs for vague generalities, with fewer allusions to the pie-in-the-sky type of "mental health" and more concentration on the fight against specific mental diseases.

Campaign vigorously for the elimination of correctible evils and abuses in the treatment of the mentally ill.

Spell out for ourselves and for potential allies the meanings of such psychoses as schizophrenia, manic-depressive psychosis, the so-called senile psychoses, along with the psychoneuroses and the psychiatric components in delinquency, narcotic addiction, alcoholism, and the like, so that people—ourselves included—will understand what we are driving at, and against.

Develop in our several states and localities concrete year-to-year as well as long-range programs based on known needs and realistic possibilities.

Seek actively to eliminate or reduce the many quasi-criminal procedures in the commitment of the mentally sick.

Help build up, on the basis of already-available knowledge, buttresses against relapses and rehospitalization of ex-patients returned to the community.

Seek out and put into practice the most effective distribution of our sparse professional psychiatric personnel.

Improve and expand volunteer service programs in psychi-

atric facilities that afford a double purpose of helping the mentally sick and widening public understanding of the problem.

Encourage sound research and training programs to explore the remaining areas of mystery in mental disease and to utilize more fully effective knowledge and techniques already available.

These are some of the measures we can push effectively in the movement. Not the least important, in my book, is the cultivation of a spirit of impatience and intolerance toward unnecessary and preventable human suffering; to remedy, as our prime short-term goal, the persisting evils and abuses in the care and treatment of the mentally sick. We have as our goals and our guides the inspiring demonstrations of remediable action in places where there were enough people who cared, people who flavored their indignation at injustices with know-how on the application of potent remedies. This immediate and urgent goal is not at odds with the long-time push toward positive mental health; it is a prerequisite for the latter.

"The promotion of positive mental health" has a progressive and reassuring ring; the idea has captured the imagination of many good-willed people, professional and lay. Certainly in the mental health movement we must push toward that ideal as far as our present knowledge and awareness of potentials permit us. But let us abjure vague and impotent generalities that only confuse the public and disorient our own purposes, and let us pay more heed to the overwhelming problem that faces us here, today, now—the menace of mental disease and its tragic toll among our child and adult population.

Let us frankly face the fact that while recent research has added considerably to our fund of knowledge about attainment of mental health, that knowledge remains incomplete, with large gaps and areas of contradiction. Yes, let us educate the public about what is fairly certain, but let us exercise more caution in promoting skimpy theories about the ingredients that go into the "good life." Let us try to pin-point our definitions about mental health so that they have maximum specificity, with meanings differentiated from other noble goals of human life.

It is my studied opinion that a major weakness of our movement lies in our over-emphasizing indefinite goals and ideals while failing to inform the public sufficiently about specific mental diseases that afflict so large a proportion of our population. I believe we will serve our ultimate purposes of promoting mental health more effectively if we come to closer grips with the current problems of improving the lot of the mentally sick.

The challenge remains great; the potential for meeting the challenge has grown ever so much brighter in recent years. There are millions of good citizens waiting to be recruited into the mental health movement. Let us gather them in, and move forward to our goals.

IDENTIFYING JUVENILE DELINQUENTS AND NEUROTICS

ELEANOR T. GLUECK *

Introduction

SINCE the publication of *Unraveling Juvenile Delinquency* [1] there has been much speculation concerning the capacity of the Social Prediction Table based on five factors in the intra-family relationships of the juvenile offenders and their matched non-delinquents (supervision of boy by mother, discipline by father, affection of mother for boy, affection of father for boy, cohesiveness of family) to distinguish at the age of six (*i.e.*, roughly at the point of school entrance) those boys who, even though not yet necessarily showing indisputable signs of delinquency, are likely to become delinquents unless appropriate therapeutic intervention occurs. There has been concern in some quarters that data initially gathered about children between the ages of seven and 17 years may not necessarily reflect conditions that existed when they were six; and there have been questions concerning the "typicality" of the sample of cases studied in *Unraveling Juvenile Delinquency,* leading quite naturally to an uncertainty as to whether we have really developed "predictive" instruments or merely a syndromization of factors that markedly distinguish the 500 juvenile delinquents studied in *Unraveling Juvenile Delinquency* from their matched non-delinquents.[2]

* Co-author with Sheldon Glueck of *500 Criminal Careers,* New York, Alfred A. Knopf, 1930; *One Thousand Juvenile Delinquents,* Cambridge, Harvard University Press, 1934; *Five Hundred Delinquent Women,* New York, Alfred A. Knopf, 1934; *Preventing Crime* (editors), New York, McGraw-Hill Book Co., 1936; *Later Criminal Careers,* New York, Commonwealth Fund, 1937; *Juvenile Delinquents Grown Up,* New York, Commonwealth Fund, 1940; *Criminal Careers in Retrospect,* New York, Commonwealth Fund, 1943; *After-Conduct of Discharged Offenders,* New York and London, Macmillan Co., 1945; *Unraveling Juvenile Delinquency,* New York, Commonwealth Fund, 1950; *Delinquents in the Making,* New York, Harper and Brothers, 1952; *Physique and Delinquency* (to be published early in 1956), New York, Harper and Brothers.

[1] New York, Commonwealth Fund, 1950. Chap. XX, pp. 257–270.

[2] Burgess, Ernest W., book review in "Symposium on the Gluecks' Latest Research," *Federal Probation,* Vol. XV, 1951, pp. 2–3; Monachesi, Elio D., book review in "Symposium on the Gluecks' Latest Research," *Federal Probation,* Vol. XV, 1951, pp. 6–7; Polier, Justine W., book review in "Symposium on *Unraveling Juvenile Delinquency,*" *Harvard Law Review,* Vol. 64, 1951, pp. 1036–1038; Reiss, Albert J., Jr., "*Unraveling Juvenile Delinquency,* II. An Appraisal of the Research Methods," *American Journal of Sociology,* Vol. LVII, 1951, pp.

It seemed to Professor Glueck and to me that there is only one meaningful answer to such speculation and that is, in the words of the eminent mathematical statistician, Edwin Bidwell Wilson, who has followed our attempts to construct "prediction" tables since the preparation of the first one (published in *500 Criminal Careers*) through 48 such tables:[3]

> A tool for distinguishing confirmed delinquents from non-delinquents may or may not be serviceable in distinguishing within a group of non-delinquents those who are potential delinquents from those who are not.
>
> One may argue about the probable serviceability of the tables for this suggested use. If one holds that the personality of an individual in respect to liability to delinquency is largely determined genetically or at any rate almost wholly determined genetically and environmentally prior to entrance to school, and that the syndrome of delinquency attributes can be observed as determinately in the earlier predelinquent age as later when delinquency has become confirmed, then one might also hold that the prediction tables would work pretty well—and one might fear that the preventive treatment might not easily be successful. If, however, one holds that personality or behavior is extremely labile and that delinquency arises not from genetic constitution nor even from preschool conditioning but from associations and conditions surrounding the individual during his school years, then one might hold that the prediction tables would work badly, but he could entertain the hope for good success with preventive treatment if only he knew to whom to apply it.
>
> *A priori* argument will not get far, howsoever it be extended. What one needs is trial and observation. . . . That the Gluecks realize all these difficulties is manifest throughout their writings; but they have not been deterred thereby from setting up prediction tables. And in respect to a table in an earlier book, namely, one which predicted behavior of civilian delinquents in the armed forces, they had a noteworthy success *a posteriori* in showing that of 200 military offenders who had been civilian offenders about 85 percent would have been so predicted to be.[4] The proof of this pudding came in the eating.[5]

115–120; Rubin, Sol, "*Unraveling Juvenile Delinquency*, I. Illusions in a Research Project Using Matched Pairs," *American Journal of Sociology*, Vol. LVII, 1951, pp. 107–114; Shaplin, J. T., and Tiedeman, D. V., "Comment on the Juvenile Delinquency Prediction Tables in the Gluecks' *Unraveling Juvenile Delinquency*," *American Sociological Review*, Vol. 16, 1951, pp. 544–548; Tappan, Paul W., book review in " A Symposium on *Unraveling Juvenile Delinquency*," *Harvard Law Review*, Vol. 64, 1951, pp. 1027–1029.

[3] A paper prepared by Eleanor T. Glueck in connection with the International Congress on Criminology, London, September 1955, entitled "Status of Glueck Prediction Studies," contains a history of this development and lists all these tables.

[4] Schneider, A. J. N., LaGrone, Jr., C. W., Glueck, E. T., and Glueck, S., "Prediction of Behavior of Civilian Delinquents in the Armed Forces," *Mental Hygiene*, Vol. XXVIII, No. 3, July, 1944.

[5] Wilson, Edwin Bidwell, in "A Symposium on *Unraveling Juvenile Delinquency*," *Harvard Law Review*, Vol. 64, 1951, p. 1041.

"Proof of the Pudding"

Since the publication of *Unraveling Juvenile Delinquency,* we have sought and encouraged opportunities first to test the Social Prediction Table by retrospective application to groups of delinquents (and in one instance it was possible to include non-delinquents), and then to subject it to the far more severe test of application in a first grade public school population.

Several validations applying this table retrospectively to boys already delinquent have been made to date and others are in process. While the findings cannot be regarded as absolutely definitive, they do afford persuasive evidence that the table is soundly based and markedly discriminative of delinquents versus non-delinquents. A review of the application of the Social Prediction Table to various samples of cases is derived from a paper prepared by the author for the International Congress of Criminology in London in September 1955.

The first validation study — made by Bertram J. Black and Selma J. Glick of the Jewish Board of Guardians in New York City — appeared in the spring of 1952. It is reported in a monograph entitled "Predicted vs. Actual Outcome for Delinquent Boys" (New York, Jewish Board of Guardians, 1952). The table was applied to a group of 100 Jewish boys confined in the Hawthorne-Cedar Knolls School in New York state, with a view to determining the extent to which it would have been possible years earlier to have accurately identified them as potentially serious delinquents. Black and Glick ascertained that 91 percent of the group would have been thus identified. It might be stated parenthetically that under the auspices of the Jewish Board of Guardians there has recently been completed a similar inquiry (as yet unpublished) concerning 150 Jewish unmarried mothers, with the finding that the table would have identified 81 percent as potential delinquents if applied several years before they were committed to the Hawthorne-Cedar Knolls School.

It is of especial significance that although the Social Prediction Table was compiled on the basis of underprivileged Boston boys largely of English, Italian, and Irish descent

and of Protestant and Catholic religions, it was found to operate so satisfactorily on a sample of New York Jewish boys; and that although it is based on boys, it yields such good results when applied to girls.

Another study, by Richard E. Thompson, entitled "A Validation of the Glueck Social Prediction Scale for Proneness to Delinquency" (published in the November–December, 1952, issue of the *Journal of Criminal Law*) establishes the Social Prediction Table as a valid instrumentality for distinguishing from among children already showing behavioral difficulties those who are true delinquents and those whose maladapted behavior is probably temporary. It shows that among a representative group of 100 boys, included originally in a research in Massachusetts known as the Cambridge-Somerville Youth Study,[6] it would have been possible (as in the study by the Jewish Board of Guardians) to identify accurately 91 percent of all the boys as either potential delinquents or as true non-delinquents. The discriminative potential of the table was found to be considerably greater than that of three clinicians (psychiatrist, psychologist, and criminologist) who had been initially charged with selecting the boys for the Cambridge-Somerville Youth Study. Thompson reports that in the light of the actual behavior of the boys subsequent to their selection for the study, the clinicians (as determined by the staff of the study) had correctly identified 65 percent as true pre-delinquents or true non-delinquents, in comparison with 91 percent correctly identified by the Social Prediction Table.[7]

In this inquiry, as in that made by the Jewish Board of Guardians, the table reveals a capacity for usefulness on boys of status and background different from that of the boys on whom it was originally constructed, for its power was maintained among the boys in the Cambridge-Somerville Study who were younger than the boys in *Unraveling Juvenile Delinquency;* on those who were of different ethnic origin; on those who were of higher intelligence; on those of better economic status; and on those who grew up in neighborhoods that were

[6] Powers, Edwin, and Witmer, Helen, *An Experiment in the Prevention of Delinquency,* New York, Columbia University Press, 1951.

[7] See p. 464 *et seq.* of Thompson's article.

not as disadvantaged as those in which the boys in *Unraveling Juvenile Delinquency* were reared.[8]

More recently (summer 1954), Thompson, in an as yet unpublished study, applied the Social Prediction Table to 50 boys appearing before the Boston Juvenile Court in 1950 who averaged 13.1 years of age (as compared with an average age of 14.6 years of the boys in *Unraveling Juvenile Delinquency*). In retrospect, he found that had the table been applied when these boys were six years old it would have been possible to determine that 92 percent would, barring therapeutic intervention, become delinquents. These boys also differed in some ways from the original sample of cases on which the table had been constructed. Not only were they younger, but half of them had no prior court appearances (all the boys in *Unraveling Juvenile Delinquency* had been in court before). The religious distribution of these boys was also different, a higher proportion being Protestants than in the group studied in *Unraveling Juvenile Delinquency*. They were less retarded in school. In a higher proportion of cases they were the sons of two native-born parents; and, in a far higher proportion, one or both parents had attended high school.

Here again is evidence of the capacity of the table based on five social factors to discriminate between delinquents and non-delinquents on samples of different composition from the original.

Another opportunity to test the validity of the Social Prediction Table came in 1954 when the Douglas A. Thom Clinic for Children in Boston (a psychoanalytically oriented clinic) applied the table to 54 boys ranging in age from six to 12 years who had been treated for aggressive, destructive, antisocial behavior. The scorings made by the clinic psychologist indicated that 83.3 percent of these boys would have been clearly identified by the table at the age of six as potential delinquents. There is some question whether the boys not correctly identified were really pre-delinquents. (This can only be determined by intensive follow-up studies.) However, the evidence of the value of the table was sufficiently

[8] *Ibid.*, pp. 467–469.

convincing to the clinicians themselves to encourage them in applying it to all their current cases (109 in number); and they are now at work on determining "what nuclear aspects of family interrelationships are reflected in the seemingly gross items regarding family life which make up the Social Prediction Table. We hope to contribute some dynamic formulations regarding this question."[9]

Still another check on the Social Prediction Table was published in April 1955.[10] This is a study made by the New Jersey Department of Institutions and Agencies in which the table was applied to 51 delinquent boys who were on parole.

TWO-CLASS PREDICTION TABLE FROM FIVE FACTORS IN SOCIAL BACKGROUND OF DELINQUENT BOYS[11]

Weighted Failure Score Class	*Unraveling Juvenile Delinquency*	*New Jersey Study*
	%	%
Under 250 (little likelihood of delinquency)	14.2	19.6
250 and over (great likelihood of delinquency)	85.8	80.4
Total	100.0	100.0

The close resemblance in the distribution of both groups of cases is striking:

> It will be observed that the closeness of the findings on the basis of the New Jersey data with the original findings in the study of *Unraveling Juvenile Delinquency* is rather noteworthy, since the New Jersey boys were selected at random, and no attempt was made to match the individual characteristics of the New Jersey delinquent boys with the delinquent boys included in the Harvard Law School Study.[12]

In addition to these retrospective checks of the Social Prediction Table, it has been applied since the fall of 1953 in two schools in New York City by the New York City Youth Board in an effort to identify potential delinquents at the point of school entrance (*i.e.*, in the first grade). These boys

[9] Report to Prof. and Mrs. Sheldon Glueck prepared by Dr. Eveoleen Rexford, director of the clinic, June 1954.

[10] "Predicting Juvenile Delinquency," *Research Bulletin* No. 124, April 1955, published by the State Department of Institutions and Agencies, Trenton, N. J.

[11] *Ibid.*, p. 10.

[12] *Ibid.*, p. 9.

(as well as those screened as true non-delinquents) will be followed up in order to determine the extent to which the prediction of delinquency checks with actual developments in each case. A description of this experiment appears in the *Journal of Criminal Law and Criminology*.[13]

The Youth Board has reported that although 17 percent of those rated by the Social Prediction Table as potential *non-delinquents* manifested some behavioral difficulties during their first year in school, 72 percent of the boys who had been identified as potential delinquents manifested such difficulties. Although the evidence is not conclusive because it is concerned only with school misbehavior, it at least indicates the likelihood of the capacity of the table to discriminate between potential delinquents and true non-delinquents. A more intensive follow-up of these boys is under way, including inquiries about their behavior in home and community. Significantly enough, the clinicians who are at work in treating half the potential delinquents (the other half is being used as a control in order to make possible a determination of the effectiveness of treatment) have already found through their own psychiatric and psychological examination of these children that almost without exception mental pathology is present (severe neuroticism, pre-psychotic manifestations, character disorders, mental defects).[14]

After this paper was written, two additional validations of the Glueck Social Prediction Table were reported at the Third International Congress of Criminology in London in July 1955. The first, by Mrs. I. Lloyd Brandon, involves a psychiatric and social study of adult sex offenders at Sing Sing Prison, New York; the second, reported by Dr. Augusta Bonnard, involves a follow-up investigation of maladjusted children treated at the clinic of the London County Council. Details will be available when these two reports are published. I am in full agreement with Professor Glueck's conclusion that "all these successful experiments involve such a variety

[13] Whelan, Ralph W., "An Experiment in Predicting Delinquency," *Journal of Criminal Law, Criminology and Police Science*, Vol. 45, No. 4, November-December 1954. Another aspect of this particular inquiry and one which provides a great challenge to psychiatrists is being designed to determine the extent to which appropriate psychotherapy will curb the development of delinquent careers.

[14] Report from Mrs. Maude Craig, director of research, New York City Youth Board, 1954.

of investigators, of subjects to whom the table was applied, and of locales as to be hardly attributable to the 'long arm of coincidence.' ''

Opportunity to Construct Diagnostic Tables Distinguishing Juvenile Delinquents from Neurotics

Encouraged by the evidence thus far at hand, Professor Glueck and I determined to pursue our quest from data available in *Unraveling Juvenile Delinquency* to construct by the weighted score method[15] three tables designed:

(1) To distinguish neurotic delinquents from emotionally healthy delinquents.
(2) To distinguish neurotic delinquents from neurotic non-delinquents.
(3) To distinguish neurotic non-delinquents from emotionally healthy non-delinquents.

Because there were relatively few delinquent or non-delinquent boys in *Unraveling Juvenile Delinquency* who were either pre-psychotic or frankly psychotic, we excluded them from consideration entirely.[16] For present purposes we also excluded those who were diagnosed as psychopathic or "asocial" because—although there was a considerable group of these among the delinquents (in a category combining the two)—there were relatively few among the non-delinquents.

[15] As our weighted score method of constructing prediction tables is fully described in *Unraveling Juvenile Delinquency* (Chap. XX), as well as in our other works, there is no need to do more here than to point out that the five factors comprising the Social Prediction Table, for example, were initially selected from among those showing the widest range of difference in incidence between the 500 delinquents and their matched 500 non-delinquents. The percent of delinquents existing in each subcategory of a factor provides the basis for a total weighted score derived from summating the individual scores on the subcategories of all five factors in which a particular boy is placed. The table itself was derived from separately distributing all the delinquents and all the non-delinquents (for whom their status on all five factors was known) into "score classes." The incidence of the delinquents and of the non-delinquents within each "score class" expresses the likelihood that a distribution essentially like the one actually obtained in such an "experience table" will be found to exist in other similar samples of cases. Whether or not such a table has applicability to samples of different composition (in respect, for example, to ethnic makeup or economic status) had to await practical demonstration.

[16] *Unraveling Juvenile Delinquency*, Table XVIII–43, Mental Pathology, p. 239.

It will be possible at a later time, however, to construct a table that will discriminate emotionally healthy youngsters not only from neurotics but also from those who are psychopathic or asocial.

It is to be hoped that similar devices for the "spotting" or "screening" or early "identification" or early "diagnosis" not only of delinquent but of emotionally disturbed non-delinquent children will be developed by others, notably by psychiatrists and psychologists, who have access to extensive and intensive case materials.

The reader is invited to consult *Unraveling Juvenile Delinquency* regarding the diagnostic procedures that led to a determination of neuroticism (including marked and mild neurotics and those with neurotic trends).[17] Briefly, a comparison of diagnostic findings made by the Rorschach experts[18] and the psychiatrist who examined the boys[19] was made and differences in diagnostic classification were resolved in those few instances in which the diagnoses were conflicting.[20]

Before proceeding to the construction of a table distinguishing neurotic from non-neurotic (emotionally healthy) delinquents, I should like to point out that we did not design the research which eventuated in *Unraveling Juvenile Delinquency* to encompass the development of the tables which form the subject of this paper. Had this been among our primary objectives, we would in the initial selection of delinquents and matched non-delinquents have deliberately included a greater number of neurotics as well as youngsters with other forms of mental pathology. The use of the data for the present purpose is purely a by-product of the larger work and must be accepted only as illustrative of the kind of instruments that mental hygienists might well develop to aid (by large-scale early identification) in the prophylaxis of emotional disturbance in the hope of preventing or intercepting the development of personality distortions.

For the present purpose analysis was made of 47 social fac-

[17] See Chaps. XVIII and XIX.

[18] Ernest G. Schachtel and the late Anna Hartoch Schachtel.

[19] Dr. Bryant E. Moulton, who was for 12 years associated with the Judge Baker Guidance Center.

[20] *Unraveling Juvenile Delinquency*, p. 242, note 8.

tors, 42 traits of character structure (derived from the Rorschach test), and 18 traits of temperament (derived through psychiatric examination). Although in *Unraveling Juvenile Delinquency* we found when comparing delinquents as a group with their non-delinquent controls that they differed markedly in the factors reflecting what we have chosen to call the "under-the-roof culture," this did not prove to be significantly so in differentiating neurotic from non-neurotic (emotionally healthy) delinquents, neurotic delinquents from neurotic non-delinquents, and neurotic non-delinquents from emotionally healthy non-delinquents. It may well be that there were more subtle aspects in the early rearing of these children which would have reflected marked differences between the two groups, but in this inquiry, at least, they were not revealed.

Examination of the factors studied disclosed the most significant differences to be in traits of basic character structure (derived from the Rorschach Test), *i.e.*, in the deposits in the personality of intrapsychic tension or conflict.[21]

Distinguishing Neurotic from Non-Neurotic (Emotionally Healthy) Juvenile Delinquents

The first "screening" table that we have developed (which, of course, requires testing against other samples of cases) has to do with differentiating in a group of true delinquents (excluding for the present those who are pre-psychotic, psychotic, psychopathic, or asocial) between those who are neurotics and those who are emotionally healthy. Sufficient differences were not disclosed in the social background of neurotic and non-neurotic delinquents to make possible the construction of a diagnostic table utilizing social factors. But among the traits of basic character structure (derived from the Rorschach Test) there are 18 (out of a total of 42) from among

[21] In order to develop suitable diagnostic instruments it was necessary to limit the initial selection of basic character traits (from among which five were to be chosen) to those not only significantly differentiating the neurotic delinquents from the neurotic non-delinquents, but at the same time also differentiating the neurotic non-delinquents from the non-delinquents who were non-neurotic (*i.e.*, emotionally healthy). Otherwise, we would, in effect, be making a comparison of delinquents as a group with non-delinquents as a group (already accomplished in *Unraveling Juvenile Delinquency*—see Table XX-7, p. 264).

which we could make a choice of five as a basis for the "screening" or "diagnostic" table.[22]

[23] *Trait* *	*Non-Neurotic Delinquents* Percent	*Neurotic Delinquents* Percent	*Difference* In percent
Common Sense—XVII–6 (354 delinquents)	92.8	64.7	28.1
Social Assertiveness XVIII–2 (288 delinquents)	52.7	17.9	34.8
Defiance—XVIII–3 (326 delinquents)	35.5	56.0	—20.5
Enhanced Feeling of Insecurity and/or Anxiety XVIII–7 (338 delinquents)	6.4	52.9	—46.5
Feeling of Not Being Taken Care Of—XVIII–9 (235 delinquents)	19.6	46.3	—26.7
Feeling of Not Being Taken Seriously—XVIII–10 (274 delinquents)	28.9	87.2	—58.3
Feeling of Not Being Recognized—XVIII–11 (298 delinquents)	29.0	54.9	—25.9
Feeling of Helplessness XVIII–12 (317 delinquents)	30.7	75.5	—44.8
Fear of Failure and Defeat XVIII–13 (306 delinquents)	36.4	78.4	—42.0
Feeling of Resentment XVIII–14 (295 delinquents)	66.7	87.7	—21.0
Marked Suspiciousness—XVIII–23 (314 delinquents)	43.5	73.7	—30.2
Feeling of Isolation—XVIII–25 (262 delinquents)	31.8	72.1	—40.3
Defensive Attitude—XVIII–26 (321 delinquents)	43.5	82.2	—38.7
Conventionality—XVIII–29 (260 delinquents)	36.8	14.6	22.2
Feeling of Ability to Manage Own Life—XVIII–32 (242 delinquents)	87.9	44.9	37.0
Vivacity—XVIII–39 (145 delinquents)	50.0	31.1	18.9
Compulsory Trends—XVIII–40 (347 delinquents)	14.1	33.6	—19.5
Introversive Trends—XVIII–42 (260 delinquents)	23.7	42.5	—18.8

* The table number following each trait is from *Unraveling Delinquency*, to facilitate cross-reference. The figures in parentheses below each trait represent the number of known cases.

In selecting five traits from among the 18, we were guided by considerations largely related to (a) the number of known cases, and (b) the size of the differences between the incidence of a trait among the emotionally healthy delinquents, on the one hand, and the neurotic delinquents, on the other. The five traits chosen, with their sub-categories and their weighted scores are as follows:

Traits [28]	*Weighted Score*
Common Sense	
Present *	73.9
Absent	28.8
Enhanced Feeling of Insecurity and/or Anxiety	
Absent	81.7
Present	21.4
Feeling of Helplessness and Powerlessness	
Absent	85.6
Present	46.1
Fear of Failure and Defeat	
Absent	86.4
Present	50.0
Defensive Attitude	
Absent	86.4
Present	51.4

[28] *Common Sense:* "The faculty of thinking and acting in the ways of the community; it may be present even if some acts of the individual run counter to accepted mores; there may be, for instance, a conflict between common sense and a fantastic thirst for adventure." *Enhanced Feeling of Insecurity and/or Anxiety:* "While insecurity and anxiety play a considerable role not only in pathological cases but also in many normal persons, enhanced insecurity and/or anxiety designates a state in which these feelings play a decidedly stronger role in the personality, either quantitatively or qualitatively, than is usual in the average person. They may, however, remain largely unconscious." *Feeling of Helplessness and Powerlessness:* "Particularly frequent and important, and very often unconscious kind of insecurity feeling, in which the individual feels he cannot do or change or influence anything, especially with regard to the course of his own life." *Fear of Failure and Defeat:* "A frequent consequence of anxiety, especially in persons with an overcompetitive attitude. Fear of failure may concern every sphere of life, not only work or play, but all human relations. It may lead either to greater effort or to inhibitions, aloofness, and to recoiling from competition." *Defensive Attitude:* "Unwarranted defensiveness, either exaggerated in proportion to the attack, or the attack is entirely imagined. The means of defending oneself are varied: they consist sometimes of a 'shell-like' attitude of warding off every approach and erecting a wall around oneself; they sometimes take a more aggressive form, as, for instance, in persons who are very sensitive to any criticism and are provoked by it to defiant or obstinate or opinionated behavior; and so on." (All terms defined by Ernest and the late Anna Hartoch Schachtel for *Unraveling Juvenile Delinquency.*)

* In *Unraveling Juvenile Delinquency,* the Rorschach traits were divided into three categories: If a trait was present in large degree in the character structure or

The highest possible weighted score that any one boy can be assigned is 414, the lowest 197.7.

The resulting table provides for four score classes.

TABLE 1. EMOTIONALLY HEALTHY AND NEUROTIC JUVENILE DELINQUENTS IN EACH OF FOUR WEIGHTED SCORE CLASSES BASED ON FIVE CHARACTER TRAITS DERIVED FROM RORSCHACH TEST

Weighted Score Class	*Percent of Emotionally Healthy Delinquents*		*Percent of Neurotic Delinquents*		*Total*
	No.	%	No.	%	No.
Under 200	0	0.0	15	100.0	15
200–299	8	21.1	30	78.9	38
300–399	92	76.7	28	23.3	120
400 and over	69	100.0	0	0.0	69
TOTAL CASES	169		73		242

Coefficient of Correlation .872

Assuming its validation, the table indicates that if a boy scores under 299 on the five traits the likelihood that he is neurotic is very great. It would appear to be a certainty that he is if he scores under 200. If he scores 300 and over there is a strong likelihood that he is emotionally healthy; this becomes practically a certainty if he scores 400 or over.

Distinguishing Neurotic Delinquents from Neurotic Non-Delinquents

The second screening device made possible by our materials is designed to distinguish neurotics who are likely to act out their aggressive impulses from those who turn their aggressiveness against themselves. Such a differentiation ought to be of assistance to clinicians who are charged with the psychotherapy of neurotics.

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dynamics, it was designated as ***marked;*** if the presence of a trait was only suggestive or indicated to a low degree, it was designated as ***slight*** or ***suggestive;*** if a trait did not play a relevant or significant role in the character structure, it was designated as ***absent.*** Ernest Schachtel has said of this categorization: "I suppose that one can find almost every trait at some time and to some degree in most persons; . . . but by the use of these classifications we want to indicate whether or not the traits in question play a considerable role in the structure of the personality." (p. 209)

Examination of the findings resulted in combining in four of five of the traits the category ***marked*** and ***slight or suggestive;*** and in one trait the category ***slight or absent.***

Of the total of 42 traits, there were 12 which sufficiently differentiated the two groups to be utilizable in a screening table.[24]

In the final selection of five traits, we were again guided essentially by considerations relating to (a) the number of known cases, and (b) the widest percentage differences between the incidence of a trait among the neurotic delinquents and the neurotic non-delinquents. These considerations re-

[24]

Traits *	*Neurotic Delinquents* Percent	*Neurotic Non-Delinquents* Percent	*Difference* In percent
Enhanced Feeling of Insecurity and/or Anxiety—XVIII–7 (104 dels., 148 non-dels.)	52.9	72.3	—19.4
Feeling of Not Being Recognized or Appreciated—XVIII–11 (91 dels., 96 non-dels.)	54.9	38.5	16.4
Suspiciousness—XVIII–23 (114 dels., 146 non-dels.)	73.7	54.8	18.9
Destructiveness—XVIII–24 (85 dels., 134 non-dels.)	47.1	22.4	24.7
Conventionality—XVIII–29 (89 dels., 117 non-dels.)	14.6	38.5	—23.9
Manage Own Life—XVIII–32 (69 dels., 119 non-dels.)	44.9	26.9	18.0
Masochistic—XVIII–34 (108 dels., 124 non-dels.)	27.8	61.3	—33.5
Destructive-Sadistic—XVIII–36 (85 dels., 134 non-dels.)	48.2	23.1	25.1
Self-Control—XVIII–38 (116 dels., 166 non-dels.)	37.9	55.4	—17.5
Vivacity—XVIII–39 (61 dels., 94 non-dels.)	31.1	6.4	24.7
Compulsory Trends—XVIII–40 (113 dels., 155 non-dels.)	33.6	56.8	—23.2
Preponderance of Extroversive Trends—XVIII–41 (90 dels., 129 non-dels.)	38.9	22.5	16.4

* The table number following each trait is a cross-reference to chapters and tables in *Unraveling Juvenile Delinquency* in which the particular trait is analyzed. The figures in parentheses are the number of known cases of delinquents and non-delinquents whose status is known in regard to the presence or absence of the trait.

sulted in utilizing the following five traits, which are presented with their subcategories and weighted scores:

Traits [25]	*Weighted Score*
Enhanced Feeling of Insecurity and/or Anxiety	
Absent	54.4
Present	34.0
Suspiciousness	
Present	51.2
Slight or absent	31.3
Masochistic Trends	
Absent	61.9
Present	28.3
Self-Control	
Absent	49.3
Present	32.4
Compulsory Trends	
Absent	52.8
Present	30.2

Summations of the highest and of the lowest possible total weighted score that can be achieved by an individual in order to establish his status on the five traits are 269.6 and 156.2 respectively. Within these limits, the neurotic delinquents and the neurotic non-delinquents were distributed within "score classes" in each of the two groups separately.

This resulted in Table 2 from which it is determined (assuming its validation on other samples of cases) that among a group of neurotics a boy scoring under 200 is not likely to act out his aggressive impulses; one scoring 250 and over very probably will do so.

[25] *Enhanced Feeling of Insecurity and/or Anxiety:* (See Note 23 for definition). *Suspiciousness:* "Indiscriminate or exaggerated suspicion toward others, not warranted by the objective situation. The person is usually not aware that he is unduly suspicious. He thinks rather that he is merely cautious or realistic, or that he is really being persecuted, and so on." *Masochistic Trends:* "A tendency to suffer and to be dependent." *Self-Control:* "The faculty of controlling the discharge and expression of affectivity (in no way identical with the faculty of the healthy and mature person of determining the direction and way of his life and what he wants to get out of his life within the given circumstances)." *Compulsory Trends:* Includes "both the classical neurotic compulsions as well as the less dramatic and less manifest cases of a rigidity that does not permit of flexible adaptation to changing situations, and usually originates from anxiety. It is an attempt to overcome anxiety and to defend oneself against it. The anxiety may be conscious or, more often, unconscious."

TABLE 2. NEUROTIC DELINQUENTS AND NEUROTIC NON-DELINQUENTS IN EACH OF THREE WEIGHTED SCORE CLASSES BASED ON FIVE TRAITS OF CHARACTER STRUCTURE DERIVED FROM RORSCHACH TEST

Weighted Score Class	*Neurotic Delinquents*		*Neurotic Non-Delinquents*		*Total*
	No.	%	No.	%	No.
Under 200	16	20.7	61	79.3	77
200–249	56	70.9	23	29.1	79
250 and over	12	92.3	1	7.7	13
TOTAL CASES	84		85		169

Coefficient of Correlation .613

Distinguishing Neurotic Non-Delinquents from Non-Neurotic (Emotionally Healthy) Non-Delinquents

Although our primary focus of interest is in the development of instruments for the early detection of delinquents, the control group of non-delinquents in *Unraveling Juvenile Delinquency* makes it possible for us to step out of the area of distinguishing between those among delinquents or potential delinquents who are neurotic and non-neurotic to consider the screening of non-delinquents as neurotics or non-neurotics. Although we are hesitant to go beyond the limits of our special field of inquiry, we permit ourselves to do so because there is significance, as will be seen below, in the fact that three of the five traits that markedly distinguish neurotic delinquents from non-neurotic delinquents also distinguish neurotic non-delinquents from non-neurotic non-delinquents. As two of the traits are different, however, there would appear to be evidence that delinquency is an entity always different in some respect from other forms of emotional disturbance. Apart from this, those who are concerned with the early recognition and treatment of emotional illness may find this third table suggestive and worthy of testing against other samples of cases.

Unlike the other two tables, in which an insufficient number of social background factors was found to differentiate the two groups involved, there are six social factors that distinguish neurotics from emotionally healthy boys among the non-delinquents in *Unraveling Juvenile Delinquency.*

The factors are: working mother (40.2% among neurotics vs. 26.3% among the non-neurotics), inadequate supervision

by mother (40.8% vs. 28.7%), unsuitable (lax, erratic, overstrict) discipline by mother (44.3% vs. 28%), unfriendliness of parents to children's friends (66.9% vs. 57.7%), meager home recreational facilities (41.2% vs. 30.9%), lack of attachment of boy to father (40.1% vs. 32.4%). However, the differences are not as great as those found in the incidence of certain character traits.[26] (Even were the differences more marked

[28] *Traits* *	*Neurotic Non-Dels.*	*Non-Neurotic Non-Dels.*	*Difference*
Common Sense—XVII-6 (441 non-delinquents)	66.9	94.9	—28.0
Methodical Approach to Problems—XVII-10 (428 non-delinquents)	25.3	44.0	—18.7
Social Assertiveness—XVIII-2 (381 non-delinquents)	3.7	31.7	—28.0
Enhanced Feeling of Insecurity and/or Anxiety—XVIII-7 (414 non-delinquents)	72.3	4.9	67.4
Feeling of Not Being Taken Care of—XVIII-9 (295 non-delinquents)	58.7	8.4	50.3
Marked Feeling of Not Being Taken Seriously—XVIII-10 (335 non-delinquents)	83.0	32.0	51.0
Feeling of Helplessness and Powerlessness—XVIII-12 (370 non-delinquents)	88.7	33.3	55.4
Fear of Failure and Defeat—XVIII-13 (395 non-delinquents)	89.1	47.7	41.4
Feeling of Resentment—XVIII-14 (296 non-delinquents)	81.7	33.2	48.5
Hostility—XVIII-22 (333 non-delinquents)	76.7	40.2	36.5
Marked Suspiciousness—XVIII-23 (377 non-delinquents)	54.8	8.7	46.1
Feeling of Isolation—XVIII-25 (321 non-delinquents)	70.5	17.2	53.3
Defensive Attitude—XVIII-26 (389 non-delinquents)	77.5	24.4	53.1
Feeling of Being Able to Manage Own Life—XVIII-32 (303 non-delinquents)	26.9	89.7	—62.8
Masochistic Trends—XVIII-34 (358 non-delinquents)	61.3	26.1	35.2

than they are, we would prefer to utilize traits of basic character structure in order to keep to a uniform method of screening large populations of children.)

Applying the same considerations as in the two prior tables to the selection of five traits on which to construct a screening table, we have utilized the following five traits presented here with their subcategories and weighted scores:

Traits [27]	*Weighted Score*
Enhanced Feeling of Insecurity and/or Anxiety	
Present	89.2
Absent	14.0
Fear of Failure and Defeat	
Present	54.9
Absent	12.0
Feeling of Resentment	
Present	58.9
Absent	13.8
Defensive Attitude	
Present	66.9
Absent	15.9
Compulsory Trends	
Present	68.2
Absent	23.3

The highest possible score in an individual case is found to be 338.1, the lowest 79.0.

Table 3 has been constructed from these five traits and (assuming its validation) is designed to distinguish neurotics from non-neurotics in a general school population (without reference, however, to pre-psychotic, frankly psychotic, or psychopathic or asocial children).

Self-Control—XVIII–38			
(424 non-delinquents).....	55.4	77.1	—21.7
Vivacity—XVIII–39			
(166 non-delinquents).....	6.4	38.9	—32.5
Compulsory Trends—XVIII–40			
(417 non-delinquents).....	56.8	15.6	41.2

* The table number following each trait is from *Unraveling Juvenile Delinquency* to facilitate cross-reference. The figures in parentheses are the number of cases in which the data were known.

[27] *Feeling of Resentment:* "The feeling of frustration, envy, or dissatisfaction, with particular emphasis not on the positive attempt or hope to better one's own situation, but on the negative wish that others should be denied the satisfaction or enjoyment that one feels is lacking or withheld from oneself." For definitions of the other traits, see notes 23 and 25.

TABLE 3. NEUROTIC AND NON-NEUROTIC (EMOTIONALLY HEALTHY) NON-DELINQUENTS IN EACH OF FOUR WEIGHTED SCORE CLASSES BASED ON FIVE CHARACTER TRAITS DERIVED FROM RORSCHACH TEST

Weighted Score Class	*Neurotic Non-Delinquents*		*Non-Neurotic Non-Delinquents*		*Total*
	No.	%	No.	%	No.
Under 200	13	10.8	112	89.2	125
200–249	10	41.7	15	58.3	25
250–299	20	76.9	9	23.1	29
300 and over	33	94.1	2	5.9	35
TOTAL CASES	76		138		214

Coefficient of Correlation .923

From this table it is determined (assuming its validation on other samples of cases) that if a boy scores under 200, there is little likelihood that he is a neurotic; if he scores 300 and over, it is very likely that he is a neurotic.

* * *

The value of such discriminative instruments will be determined only by experimental application. The problem of skillful administration and interpretation of Rorschach Test findings may limit the usefulness of such instruments. It may be, however, that simpler projective tests can be developed which would elicit the data needed.

Perhaps a group Rorschach Test (or other projective tests) could be devised which would focus on the particular traits of basic character structure that appear to be significant in differentiating between neurotic delinquents and neurotic non-delinquents, between neurotic delinquents and non-neurotic (emotionally healthy) delinquents, and between neurotic and emotionally healthy non-delinquents.

A beginning must be made in utilizing tables such as the three presented here in order to determine how well they apply in other samples. Some such syndromization of traits or "symptoms," if you will, makes possible the arrival at "diagnoses" by methods other than purely psychiatric, and by persons other than psychiatrists. From the trend of evidence in the checks that have thus far been made of the Social Prediction Table developed in *Unraveling Juvenile Delinquency,* we are encouraged to think that we have in these three new diagnostic instrumentalities additional means for early recognition of

neuroticism in delinquents and non-delinquents. We envisage the use of these three discriminatory tables as a supplement to the Social Prediction Table in order that following the "spotting" of potential delinquents a further step can be taken in distinguishing the emotionally healthy delinquents and non-delinquents from the neurotics, and also in sorting out from among neurotics those who are likely to act out their aggressive impulses and those who are not. If, in addition, we can develop a table designed to identify those who are psychopathic or asocial, the mass screening of children (through group projective tests) at the point of school entrance would be closer to realization, making possible a concerted attack on delinquency and emotional disturbance in their incipient stages.

CULTURAL ELEMENTS IN GROUP PSYCHOTHERAPY: SOME PROBLEMS FOR STUDY*

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THE relevance of a patient's socio-cultural group memberships to his performance in at least the opening meetings of psychotherapy groups has, to the best of my knowledge, received no systematic study. Nor is this paper going to provide us with the findings of an orderly inquiry into this problem. Rather, out of retrospective impressions, with the insights of hindsight, I shall describe what look like repeated patterns of patients' behavior — patterns which seem to be related to the patients' cultural affiliations as well as to the "cultures" of the therapy groups themselves. The patients' behavior was observed and recorded in a dozen out-patient clinic therapeutic groups.

Unfortunately, in the original study, reported in full elsewhere,[1] we had no curiosity or hypotheses about the patients' ethnic or social class backgrounds. We therefore failed to obtain from all patients, in any systematic way, the facts which seem now so essential.[2] What I present here are therefore hunches derived in retrospect from incomplete data — questions for further study.

The patterns are drawn from records on group psychotherapy sessions composed primarily of neurotics. I am not referring to our group work with hospitalized psychotics who, as I saw them, seemed more or less acultural. One might postulate that *if* their cultural beliefs and values and the content of the rôles they had been exposed to in childhood, adolescence, and their young adult years had seemed applicable and supportive to them in the extremely stressful situa-

* Presented at the first annual western regional meeting of the American Group Psychotherapy Association in Berkeley, Calif., June 1954.

[1] *Group Psychotherapy: Studies in Methodology of Research and Therapy*, by F. Powdermaker and J. D. Frank. Cambridge, Harvard University Press, 1953.

[2] Knowledge of our many patients' G I Bill student status served merely to conceal occupational and social class status. Such data cannot lead to any valid generalizations about the relationships between patients' social position and their differential reactions to group psychotherapy.

tions to which they adapted by becoming psychotic, they would never have become psychotic.

Unlike the acultural psychotics, the psychoneurotics in our clinical study were the prisoners of their cultural heritage. Either the don'ts of their social milieu had overwhelmingly failed for them to counterbalance the do's, or the do's had never been quite fulfillable — and the men were still working on them. Finding themselves for the first time in their young lives seated in a room with a psychiatrist as a designated "leader" and with from five to a dozen other patients present, most of the men were still working on overwhelming don'ts and unfulfilled do's. The fact that the don'ts and the do's were in many ways irreconcilable and yet binding for those patients must, we may hypothesize, have affected the nature of the transition they had to make to the group psychotherapeutic cultures.

And how may we describe them — the cultures of our therapeutic groups? Their values included and induced the expression of true affect, especially anger and other elsewhere allegedly unacceptable feelings. Their mores, sometimes explicitly stated by the psychiatrist at the early sessions of a group, encouraged the revelation and analysis of personal weaknesses and inadequacies in performance in family, work, and school situations outside the therapeutic group. (Later, in-group phenomena would be studied.) Social skills, built into the initial reciprocal rôles of patient and therapist, varied principally with the style of leadership offered in early meetings by the psychiatrist. Such leadership style, a major differential element in the therapy group cultures, may be schematized and dichotomized as follows:

The psychiatrist initially induced either primarily patient-to-patient relationships or patient-to-therapist relationships. In fostering patient-to-patient relationships, the psychiatrist may have sat by passively, an interested observer, but somewhat peripheral to interaction among the patients, for either explicitly planned reasons or less manifestly rational motives of his own. He may actively have deflected the first few patients' questions or statements directed his way, throwing them back to the group or to another patient. His actual behavior and attitudes may have varied considerably from those of another therapist. Still, to the observer, what ap-

peared in one *type* of group culture, during early meetings, was the development of much interaction among the patients and the organization of a group structure which placed in the topmost position one of the patients.

In the other type of group culture, in which the psychiatrist's style induced patient-therapist relationships, the interaction pattern revealed quantitatively less patient-to-patient give-and-take and a resulting group structure which unquestioningly set the therapist in the highest status and ranked the patients somewhat competitively in slots further from or closer to the physician. The data we had on patients' improvement enabled us to say that neither of these approaches induced more patients to stay on in or to drop out of treatment during the early meetings. From both types of group, under both types of therapist style, patients dropped out.[3] But who were these patients who dropped out of either type of situation? Here, I believe, knowledge of certain cultural facts about the patients is germane.

Why? What are the theory and relevant studies? Dr. Paul Barrabee of Harvard recently reported on an investigation, done at Boston Psychopathic Hospital, of family patterns among Italian, Irish, Jewish, and Yankee patients.[4] Since some of his findings agree with parts of a study I did some years ago in Chicago,[5] I should like to make somewhat free use of his formulations, combining them with mine, and then relate some of these factors to the cultures of our therapy groups.

Barrabee describes the Irish and Italian families as having what he calls "respect (or position) solidarity," in which the individual is subordinate to the group. In this type of family, there may be anxiety over one's place or position in the family; there are "status controls" but no rewards. One is expected to respect the dominant parent figure. By comparison, Barrabee finds in the Yankee and Jewish families what he calls "love solidarity," in which the individual is valued

[3] See Chap. IV, "Patients Who Left Groups," *ibid.*, pp. 77–94.

[4] "How Cultural Factors Affect Family Life," by Paul Barrabee. *Social Welfare Forum, 1954.* New York, Columbia University Press, 1954, pp. 17–30.

[5] "Some Social Class Differences in the Family Systems and Group Relations of Pre- and Early Adolescents," by H. S. Maas. *Child Development,* Vol. 22, June 1951, pp. 145–152. (Reprinted in *The Adolescent: A Book of Readings,* by J. M. Seidman (ed.). New York, Dryden Press, 1953, pp. 456–464.)

qua individual. In this type of family there is anxiety over being loved, a condition often depending upon adequate rôle performance. There may be a sense of indebtedness to the mother who expects obedience as her moral right for the ostensible good of the child — not the group.

In a comparable study, we observed and interviewed early adolescent boys and girls in neighborhood center youth groups. Our data on slum area children, many of whom were Mexican, Negro, and Italian, were compared with comparable data on largely Protestant, middle-class Caucasians. In the latter group we found a much more "open, ostensibly equalitarian and flexible relationship" between the youths and their parents, in the lower-class and ethnic groups "a psychologically closed, hierarchical, and quite rigid parental relationship with children."[6] Psychological distance between parent and early adolescent child seemed much greater in the lower-class than in the middle-class groups; working mothers and otherwise busy parents were often in many ways remote and when present gave orders and peremptory physical punishment to their adolescent children. The children seemed to respond in early adolescence with fear of parent figures. In the neighborhood centers they seemed markedly ambivalent about the adult group leaders; they tested them, challenged them, or responded with passive compliance to requests.

The middle-class or "core culture" children frequently shared decisions with parents, at times openly opposed or manipulated them to the child's own ends, and clearly showed no fear of adults, but rather a capacity to speak as equals with them, to accept them, and to get along in their club meetings quite competently without them. Unlike the slum area adolescents, these boys and girls had no trouble with adult group leaders; their difficulties were more or less with one another, their peers.

The slum area early teen-agers had their street gangs in which physical power — expressed frequently as physical violence — was accepted, even highly valued, and led for some of them to what they seemed unable to attain in their respect or position solidarity families — a high status. For others, submissive subordination was an acceptable, comfortable,

[6] *Ibid.*, p. 147.

familiar position. At home, father was not replaceable; only in his absence, in the street gang, could father-leader status be fought for and achieved.

Among the middle-class youth, parental approval, if not love, had long been awarded them as children when such rôles as "good boy" or "good girl," "good school pupil," and "good child in the neighbor's eyes" were adequately fulfilled. Competitiveness among age-mates and siblings arose for the love and approval of parent-adults — whether father, mother, teacher, or neighbor. The adult was the source of rewards, not a symbol of fear. For the healthy early adolescent in the middle classes who had internalized parental and other adults' sanctions, the adult had served his purposes, and could now be questioned, disposed of, or supplemented if need be. On the other hand, the authoritative, often punitive, overtly aggressive, to-be-respected-and-never-questioned parent, store owner, and policeman, known to children and adolescents in the roving street gangs in Chicago, remained a distant and fearful symbol of adulthood — at least for the slum area boys and girls we studied.

Counterparts of some of the latter and some of the former as young adults entered our therapy groups. Some of these groups, remember, quickly became patient-patient or therapist-patient cultures. What happened? Let me describe seven of the patients, their behavior in the early meetings of two groups, and their backgrounds. I shall have to limit myself to very brief comments about even these few.

Fio [7] entered the group at about the fourth meeting. With characteristic force, after he got the lay of the land, he burst in with direct counsel to another patient who was expressing concern about sex play with his girl friend and masturbation. Fio seemed openly aggressive, called a spade a spade, and evoked an intervention from Dr. A in which the latter sought to protect the self-revealing patient from Fio's direct approach. Dr. A in this group characteristically fostered therapist-patient relationships. Although he encouraged the expression of hostile feelings, their overt and facile expression by patients like Fio seemed to evoke his concern for those

[7] All patient names used in this paper are pseudonyms. Other data are somewhat disguised to conceal patients' identities.

other patients whose tolerance for such hostility seemed to him to be low, and he regularly suppressed patients like Fio in his group.

Fio had run away in mid-adolescence from his Italian-ethnic family living in Baltimore slums. The family, as described by Fio in an interview, would be characterized by Barrabee as a respect-solidarity family. Father's word was law. In opposition and hatred, Fio could only flee. Following trouble with officers in the military, Fio faced a series of problems with civilian bosses. Each job was abandoned. In a therapy group in which the parent-figure intervened, Fio could not remain. Fio never returned.

From the same group, O'Hara, with a similar approach to other patients and an obvious dread of Dr. A, came every other session for four of the early sessions, then never returned. O'Hara had not completely lost contact with his respect-solidarity family. In an interview he described his sporadic, hopeful visits to his parents' home, bringing a dozen eggs as a gift, and then the periods of withdrawal and not allowing himself to visit. O'Hara worked as a pole climber for a utilities company. The don'ts of "don't show disrespect to the father" and "don't live for yourself but for the group" —for example, "turn in to the family faithfully all your salary" — were too much for him. Ostensibly he quit the therapy group because Gold, another patient, talked of his former officer status in the Army, and, as O'Hara told me, "I swore I'd kill every officer I met, once I was out." Dr. A, incidentally, was known to have been a major in the Medical Corps.

In this group of Dr. A, Gold stayed on, ignoring the other patients and discussing in the rôle of good patient for Dr. A all his fantasies of terror as well as his personal inadequacies on the professional job he was engaged in. Dr. A responded with interest and attention to Gold's appropriate performance; Gold was the bellwether, the model patient in this milieu. Gold had learned from his mother the do's of a good son and a good student; that he had not gotten all the approval and love from his father to which he believed himself entitled for such good performance — that his sister won his father's love instead — may have been related to Gold's repeated, lifelong efforts to excel in situations in which approval from a superior

might be gained. For the milieu of Dr. A's group Gold had been well acculturated, and the transition was, to this type of therapy group, an easy one for him. So much for the first three patients and Dr. A's group.

In Dr. B's group, Prescott, from a long line of Virginians, and Reisman, a young Jewish veteran, lasted only a few sessions. In terms of familial values, relations with an overly approving mother, suppression of unpleasant affect and occupational aspirations, Prescott and Reisman were in many ways comparable to each other and to Gold. Dr. B, however, was quite different in style from Dr. A, and the patterns in these two groups were quite different. Dr. B sat back, almost actively withdrew, relating patient to patient when one of them did address him. He explained that at first he did not want to become buddy-buddy with the patients, so he held himself aloof. In turn, Prescott and, then when he had left after three meetings, Reisman, became the pseudo-therapists or leaders of this group. They solicited discussions of patients' problems and attempted to analyze their complaints, but there were no rewards from the parent-figure for even this performance, and their interests in the other patients seemed completely spurious and manipulative. When Prescott complained that Dr. B did not give "enough Freudian interpretations," he was rebuked; Prescott quit. When Reisman quit, after having played the pseudo-therapist rôle for a few sessions, he remarked not too cryptically, "I didn't have the privilege of being the only one there, and there was no particular path to go on." He had proved he was "the top man saying the most important things." But Dr. B—who after an early meeting said, "I was afraid to say something to any one man; it might seem too significant"—was giving no approval or other rewards for such good performance. This was an unfamiliar parent rôle for Reisman and Prescott. For someone like Reisman, highly competitive with peers and siblings, the do's as determined by the parent were not clear enough—and truly there was "no particular path to go on."

For Bocci, a third patient in this group, the ninth and youngest child in an Italian-ethnic family, whose father had for years dashed cold water in his face to wake him for work in the mornings, the culture of Dr. B's group was perfect. Bocci was the chief and successful contender for the leader's

position—aggressive, energetic, an old hand in an unsupervised boys' group. To Olem, also from an economically depressed, hierarchical, respect-solidarity family—to Olem, fearful of Bocci but even more fearful of Dr. B, symbolically, the patient-patient relationship structure was essential. Had Dr. B been active, inducing doctor-patient relationships, Olem would have fled the group in fear. Relationships with peers—fellow-patients in a street gang—and support from them, even in a low-man status, was essential before Olem could approach the fearful omnipotence of the parent-leader-adult-psychiatrist. Tolerance for aggression from peers, in a group unsupervised by adults in the back alleys of the city, had been well learned. The do's of this group's culture were not overwhelming for Olem or Bocci; the paramount don't was the familiar "don't express true feelings to the father." One could survive well among siblings and age-mates, fighting to a top rung in the hierarchy or finding and hiding comfortably in a subordinate position. In the group cultures where the therapist sat back, the child of the gang and the slum was initially at home. Uncontrolled aggression and counter-aggression or submission among peers were not his problem. Intimate feeling relations with the adult were the uncompensated for don't.

In such a group culture, however, for Prescott and Reisman (and for Gold), whom some adults had rewarded and for whom most adults were non-threatening, survival was impossible. Other patients were, as Reisman said, just "sticks." For Gold they were the somewhat frightening enemy. They were not supports, as they were for Olem (and O'Hara); they were not essential for one's own superordinate position, as they were for Bocci (and for Fio). For Gold, they were in the way in his seeking of the attentions and approval of the psychiatrist. For him, for Reisman, and for Prescott, only the therapist was important.

In limiting this discussion to but two groups and seven patients, I have presented scanty data. This has been done, obviously, to avoid confusion in the limits of time. I could easily have presented twice as many patient-examples, drawn from the 10 other groups in our study. Even then, however, I should be able to offer only tentatively the following propositions:

1. Neurotic patients drawn from respect-solidarity family cultures, in which the group is valued over the individual and the parental status is unapproachable and fearful to the child, have a less difficult transition to make into a therapy group if the latter values and fosters patient-patient relationships. Such patients today are likely to come from certain lower-class Old World milieus.
2. Neurotic patients drawn from affect-solidarity family cultures, in which the individual is approved for his rôle performances and the parent is seen as accessible and manageable, have a less difficult transition to make into a therapy group if the latter sanctions and induces patient-therapist relationships. Such patients are likely to come from non-ethnic American and Jewish middle-class families.
3. Analysis of the do's and don'ts in the cultures of therapy groups and their relationships to the differential sanctions and taboos in the cultural groups from which patients are drawn may help explain why some patients are initially "good" patients in the therapist's eyes, others "bad." It is possible, moreover, that such phenomena as Oedipal situations, which we think we see re-enacted time and again in the group, may have quite different meanings for the patient from the Old World slums, for whom the father rôle has always been an unattainable don't, and for the neurotic middle-class scion who has played father (and many other rôles) many times but whose overwhelming don't has been to be himself.

SEPARATION OF THE PARENTS AND THE EMOTIONAL LIFE OF THE CHILD *

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IN this paper I shall confine myself to the effects on the emotional development of the child of the prolonged and essentially permanent absence of one parent from the home, and comment only to a limited degree upon those even more unfortunate situations where both natural parents are absent, presumably permanently so. I shall consider only those situations, too, where the absent parent, though away from home, is still living and may or may not be accessible to the child at stated intervals. Furthermore, because of the fact that in 75 to 90 percent of any series of broken homes coming to our attention it is the father of the child who is absent, my remarks will be primarily directed to the effect of his absence on the child's development. To be sure, a certain percentage of mothers do desert their children, or their children are taken from them by direction, and when this happens the basic problems set for the child vary in kind and in intensity; to these I shall lend some emphasis. Yet the prototype of the broken home is that where the father is absent and the mother has the sole care of the children. In the fourth place, I shall not attempt, except tangentially, to outline the different effects of the absent parent on boys and on girls as such. Rather I would select for our consideration some universal effects upon children regardless of sex and some fundamental problems in emotional development that are affected by the absence of the parent.

Specifically, I shall speak of the effects of parental separation upon:

- The child's developing "concept of self"—the ingredients that go to establish his own inner sense of separateness, integrity, worth-whileness, and security as an individual.

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• The child's "concept of human beings" that comprise his outer world—human objects to which he must make a definite feeling orientation and to which he is expected to respond, as a child and later as an adult, in an acceptable and an efficient way. (To the technically minded perhaps it is correct to say that I am directing my attention to the possible effects of parent absence on the ego development of the child.)

We shall begin our discussion by a glance for a moment at what the parent is to the child; *i.e.*, what are some of the most important attributes of the parent as far as the child is concerned and as he or she is seen through children's eyes and feelings at various stages of development. In the light of these many parental rôles (and they are many and complex), we ourselves shall be better able to appreciate the effect of deviations from these rôles which are brought about when a parent leaves. To the child at any age—and particularly in earliest childhood—the parent (both parents) is the source of life itself in the form of food and clothes—the one single factor of basic significance in establishing within him a sense of security and in indicating probable continuing survival. He predicates his physical integrity, including later his sense of anatomical integrity, upon the presence of parents who will care for his bodily needs and will protect him from aggressive and mutilative attacks by others.

To this basic feeling of security of body and its associated concept in the child's mind that parents through their presence alone will maintain it are added other elements in the child's over-all estimate of his parents. They are the givers of gifts that may be used as objects for gratification and the givers of love in and by itself or as symbolized by these gifts. They are in great measure the omniscient givers of information that explains his world and omnipotently protects him in it. In their seeming omniscience and omnipotence also they control his life, direct his behavior, and emphasize ideals of conduct in individual and group living.

These are the elements of the fundamental concept of the parent as it exists in the mind of the young child. Obviously many modifications of this biological or strictly "dependency-need" concept of the parents must take place as the child advances toward the establishment of a necessary concept of himself as an independently (relatively independently, of

course) behaving individual or "self," at which point he is expected to refer his behavior to inculcated or incorporated mental images of these parents which, for good or ill, are to be the most powerful models that he will have within him.

It should be emphasized, too, that these parental concepts will in large part determine what the child's notions of human beings as a whole in his world of the present and the future will be like. The human objects to which he will direct, or from which he will withhold, his love in the expectation of gratifying and satisfying experiences will be determined in large part by his infant and childhood concept of the parent figures. These are models of the human love objects in his environment.

On the other hand, it is not difficult to conjecture that the child's basic concept of self is also determined by the variations in behavior on the part of his parents as they relate to the security feelings mentioned above. His worth-whileness and his intrinsic value of himself as an individual is first, and hence most crucially, demonstrated to him by the expression of his parents' own love, care, attention, protection, gifts, companionship, etc., through their presence (in the earliest years almost omnipresence) in his vicinity. One's concept of one's worth of self is inevitably a product of another's expressed need or want.

If these hypotheses and assumptions of the importance to the child of these parental relationships in the formation of both his concept of self and his concept of human beings are correct, it is possible to examine and outline the effect upon the child of any and all deviations of parents from the most efficient model for which we could hope.

We have selected for consideration one trauma, the deleterious effect of a prolonged or permanent parent absence upon these concepts. These varying effects in varying situations are brought to our attention through numberless clinical observations.

Let us start, first of all, with the child whose parent left the home before the child was two or three years of age. He has, let us say, never seen the father or cannot remember ever seeing him. It is natural for such children, at four or five and thereafter, to note the difference in their own homes; and their questions as to "Where is my father?" or, more point-

edly, "Who is my father?" are either answered evasively or are virtually ignored by the remaining parent. Naturally the mother is in a very difficult position because she is caught in a conflict which she knows she has, in part, and which, regardless of what she answers, she is going to transmit with full force on the child. If she tells the child that the father left because he did not love them, the child himself feels—just as does she—for the first time a sense of worthlessness. He feels that he must have been (and still is) of little worth or his father would never have left. There is, too, a questioning of the absolute worth of his mother, for she too was left. If the mother states that she left the father because they "could not get along together"—thereby trying to minimize the shortcomings of the father in the eyes of the child—the child may very well feel that perhaps his father was all right, perhaps even better than mother really, that mother is keeping his father from him, and that the latter really would like to be home if mother would only let him. In this situation the child's concept of the mother is that she is in some part a depriving mother—depriving him of the love and companionship of a father, not because he, the child, is at fault, but because the mother and father didn't like *each other*.

Assume for a moment that the mother tries to soften the blow by taking it out of the realm of personalities or of likes or dislikes and placing it instead in the area of economics. She states, for example, that father left "because he could not support us," really meaning of course in many situations that "he *would* not support us." Immediately the child's concept of his father, of fathers in general, and of men in general is that they are unable to care for mothers or children and that under such circumstances men in general may leave their children or—even worse—ladies may leave or abandon the fathers of their children. To go beyond this rumination of the child: in the clinical setting it is not unusual for a further equation to be arrived at, namely, if mothers can so easily abandon husbands, they perhaps may at some time, if provoked enough, just as easily abandon the small prototype of husband, the male child, *i.e.*, himself. And this certainly does not add to the child's sense of security, nor does it add to his estimate of his own worth in a world populated by human love objects.

Another explanatory device is based on the assumption that

all such feelings may be prevented if the child is led to believe, through either expressed or unexpressed hints, that the absent parent is dead. This is a solution used more often than one would suppose. By such a technique the remaining parent escapes an expression of her feelings only temporarily, and the child does not escape for long either. Almost inevitably the child learns or has to be told that the absent parent is not really dead; and the acute, drastic, and painful modifications that he must make at that time are equally traumatic, if not more traumatic than the changes in concepts and feelings that must occur in the light of the other explanations commented on above. They involve, too, a marked change in his estimation of the trustworthiness of all human beings. If a parent can lie about a thing so important to him, the parent certainly cannot be trusted in all other explanations which he has received or in the future expects to receive on demand.

There is a specific anxiety that is aroused in the child as he grows older—and particularly in adolescence—following a spurious explanation that the absent parent is dead. As the child begins to doubt this explanation or as he is later given indirect or direct inklings as to the truth, he is tortured by the possibility that he is an illegitimate child: that his father left before he was born because his father and mother were never married or that he was illegitimately conceived and the marriage took place merely "to give him a name." This is a very logical deduction on his part when the remaining parent attempts to correct the original falsehood by explaining that the father disappeared before the child was born or shortly thereafter.

Finally, there is the possible deduction too—in separations taking place in the child's infancy and earliest years—that his father and mother got along reasonably well and lived together until he was born. In this situation it is very easy for the child to assume that if he hadn't been born the parents would be together—that he was the *cause* of the separation. They wanted each other but did not want *him.* One can estimate the child's own sense of worth as an individual human being in the midst of such logical ruminations. And such ruminations are the only logical ones the child can make in the light of the information that he is allowed to receive in many broken homes.

As I stated above, the mother's position following a separation in the early life of the child is a difficult one when she is asked to explain to the child the absence of the father. My thesis is that there is no explanation that will not have an adverse effect on the developing self-concept and human-being concept of the child. These effects may be and should be minimized, but they probably cannot be entirely eliminated.

Let us turn now to the effects on the child of a separation of the parents at a later stage in his development, placing the separation at a time after the child has received the benefits of an unbroken home and has had the opportunity of forming positive relationships with and concepts of both a father and a mother. I need not tell you that there is usually a long period of strife and discord in the family to which the child is subjected before the separation actually becomes a fact. He has formed to a certain degree a working relationship with both parents; both have satisfied his needs to some extent as love objects, and with respect to each he has formed a definite concept of his own self-worth and also a notion of the worth to him of father and mother—and of the value and worth of adult male and adult female human beings.

The positive aspects of both of these self and not-self concepts come under severe attack during the distressful times preceding parental separation. If the child is inclined to believe or take sides with his mother perforce in her continued and severe devaluations of his father, he may acquiesce, but he does so with poignant feelings of guilt because of the necessary modification of the concept of himself as one who must show expected love of and devotion to his father. The same arousal of guilt is caused as he listens to his father's complaint of his mother and to the citing of her deficiencies as a mother. The "good child" picture of himself that he has constructed for himself as the best source of security obtainable in this world demands that—if he is to remain a "good child"—he must retain his love for both parents. Circumstances just won't allow him to do this.

Even worse for the child is the feeling that his basic and fundamental security may be in large part swept away if either parent leaves him. Both parents are necessary to take care of his needs, the satisfaction of which he has ascribed as being particularly and peculiarly the rôle of one and not

the other parent. Despite repeated attempts at reassurance on the part of the parent who is to remain with him, he is rarely convinced that that parent alone has the power to supply all his needs—and, of course, this intuitive feeling of the child is essentially a correct one and is so proved in time.

When we turn at this time to the other aspect of our discussion, namely, the effect of these devaluative maneuvers and strife between parents on the child's concept of human beings as a whole, we again note some necessary modifications in his estimations of human worth. These are serious and can be far-reaching. For the child the behavior and worth of parents are the models for his evaluation of the behavior and worth of all men and women. Particularly do they constitute the only closely and intimately available model of the expected love of one human being for another and of one man for one woman. The expected and hoped-for stability of love relationships of all persons—including those directed by and directed toward *him*—must be drastically modified at this period. Love relationships with human beings no longer appear sufficiently stable—they may be hazardous and lead to eventual hatred and abandonment. At least the child will henceforth be forced to consider them extremely conditional and capricious, and his reluctance to enter himself into such relationships and his attitudes toward them when he does may be patternized at the time of his parents' separation and lead to considerable future distress.

In short, if one has the opportunity to study a child intensively just before, during, and after parental separation, one is struck by the similarity of the child's reaction to the well-known "grief reaction." He tries desperately to withdraw the emotional investment he heretofore had in the now absent parent and struggles to place it elsewhere in other persons, objects, or interests in his environment. He cannot allow such positive feelings to persist or he feels guilty in respect to his negative feelings or hate for the *remaining* parent. His normal ambivalence toward the parent who has left him is heightened and his guilt becomes greater. To acquire any kind of security and peace he must get rid of both his positive and his negative feelings regarding the latter—and this process, like the mourning process, is a long and painful one.

Following the essentially permanent separation of the pa-

ents, other problems arise which in the main are more or less directly related to the possibly changed attitudes toward him on the part of his parents and to the difficulties involved in his attempts to maintain a desirable relationship with both of them—with the present parent in his everyday life and with the absent parent whom it may be possible (or expected of him) to see at stated intervals.

Assume for a moment that the child stays with his mother. Any number of changes may take place in her attitude toward him, and they are easily detectable.

1. For example, he may become to the mother—and he may sense that he has become—a burden. He may be regarded as an economic burden making it necessary for the mother to work both outside and inside the home. Or the fact of his existence and his presence may become to the mother a definite block to her desire for social relationships with adults of both sexes, or to her desire to marry again, or to the carrying out of a previously desired career that had been thwarted by her marriage in the first place.
2. The presence of the child may be a continuing example to the mother of her own deficiencies—notably her failure in her attempt to maintain a home, to satisfy a husband, to be a completely adequate wife and mother. Doubts concerning her abilities along these lines may have existed before her marriage, and its breakup may have confirmed them. The child in turn is a continual reminder and reactivator of these long-existing doubts and fears.
3. Directly associated with these changed attitudes toward the child on the part of the mother is the tendency for her to identify the child with the absent husband, and particularly to identify the child with all the bad and undesirable aspects of the father's make-up. This may happen whether the child is a boy or a girl, though obviously it occurs more often when the child is a boy. Here again the causes may reflect the mother's deep, unconscious, and unrecognized feelings about all males and only secondarily her feelings concerning a particular one—the child's father.

In short, the child may have become an economic burden, a social burden, and an emotional burden to the mother and he begins to realize it. In this situation the child necessarily fears that he is in danger of being abandoned, deserted a second time, this time by the mother. His feelings and his responses when he is seen clinically are those of the terribly insecure and fear-ridden child who in his behavior is attempting all the maneuvers that he can to attain or to maintain what to him seems to be a security position. He may try docility, passivity, and quiet withdrawal to make himself into the "good child" that the mother must love. More often he will fight back with hyperaggressiveness, hostility, and insubordination. He may attempt a regressive move to the behavioral levels of infancy when, he remembers, he was really loved and wanted, or resort to frequent feigned illnesses to regain an attentive response of love and care. Whichever one of these security tactics he may try—and any given child will usually attempt all of them in turn—he usually is unsuccessful in meeting these newly expressed hostile attitudes on the part of the mother.

On the other hand, it sometimes happens that the mother's changed attitude is one of increased positiveness and devotion to the child—and overwhelmingly so. The mother, in her attempts to demonstrate that she is an adequate mother in the face of a separation from the father (with all that this involves concerning her estimate of her own worth) may become extremely oversolicitous and overprotective of the child. His every wish has to be satisfied and his every need gratified in order that her child may appear before the world as a happy and contented youngster. He is figuratively smothered with love and gifts so that the mother may prove to herself and to him that she has not failed and will not fail in her rôle as a mother. In the absence of the father the child becomes the single, all-inclusive libidinal investment that the mother makes, to the exclusion of an investment of any part of herself in other people or other interests. I need not emphasize the harmful effects that such an excessively overprotective attitude on the part of the mother has on the child because, in the first place, of the impossibility of complete reciprocity of feeling toward the mother on his part. Such reciprocity is not

possible in the case of the child in the intact home, nor is it possible when one parent is permanently absent.

You are aware too, I am sure, of the harmful effects of such maternal behavior in relation to the orderly development of the child—to the necessity for eventual separateness and individuality and to the initiation and beneficial completion of those maturity thrusts that depend on the widest possible association of the child with other human beings, both children and adults. And, finally, there is always to be considered the deviated and unrealistic conception of self-worth and self-value that is inculcated within the child when he is the sole object of the mother's love and overprotectiveness.

In short, when this becomes the relationship of the mother and child, the mother's needs rather than those of the child become the real motivating factors in maternal behavior.

There are additional problems set for the child whose parents are separated which, though I shall mention them but briefly, are extremely important in that they may involve the child in acute conflicted feelings resulting in guilt and a consequent modification of his internal notion of his own worth.

The child of the broken home feels "different" from other children. He is continually asked by his colleagues to explain the absence of the parent, to answer the question as to where the parent is, to give judgments to them as to which parent he feels is or was at fault, and to declare which of them he likes the more. In addition to his not knowing the answers to all these factual questions, he is not able without considerable guilt to express his true feelings in the matter. Children in general are particularly curious about broken homes and the causes of them, their curiosity arising, of course, from the possibility—however remote it may actually be in reality—that such a fate may befall their own homes. The child of separated parents is a source of information for them about facts and feelings that they hope may lead to their own reassurance and security, and they can be unwittingly cruel in their approach. At any rate, the child is made to feel "different."

Then there are the conflicted feelings that arise at the time of necessary visits to the absent parent: the child feels guilty if he leaves his remaining parent and he feels particularly guilty if he feels he had a better time there than he ever

has at home. On the other hand, if he does not wish to visit the absent parent, he also feels he is a sinful child. Unfortunately he is subjected many times by both parents—by the one at home and by the one he visits—to expressed or unexpressed hostility toward, and devaluation of, the other parent. He becomes an instrument for each parent to prove that he is the better parent, that he loves the child more, that the other parent's care of him is inadequate and the cause of all his unhappiness and deficiencies in conduct or attainments. The child attempts, if he can, a double, mutually exclusive attitude of love and devotion to both parents, in order to prove to himself that he has two good parents who love him; but he rarely succeeds in this and his attempts are usually transitory and are inevitably guilt-laden.

Such visits to absent parents—their time and duration—are sometimes set by law and occasionally they are badly set. One suggestion that I might make in this respect is that visits, if demanded at all, should not be restricted to occasional single days or week-ends or to one or two holidays a year. Such short visits merely result in compulsion on the part of the parent to shower the child with innumerable gifts, and with attendance at a score of entertainments of various sorts to try to indicate to the child that this is the kind of idyllic life he would lead if he lived there all the time—a much happier existence than he now has in his permanent residence. The child returns home with little or no real appreciation of the real worth of this parent and with no feeling that the parent really loves him for his own sake. Visits should be long enough for the child to appreciate both, and particularly for him to maintain a feeling of really belonging somewhat to the other parent and to feel that there can be a meaningful continuity of this relationship.

In summary, then, I have tried to sketch some of the effects of the separation of parents on the emotional state and on the emotional development of the child. I have confined my remarks at this time solely to the effects of parental separation of any kind where the permanently absent parent is still living, believing that these are some of the universal feelings of children thrust into such circumstances, regardless of the fine type imbedded in various legal documents.

I have stressed the ill-effects of such separations upon the

all-important adequate and efficient "concept of self" and "concept of human beings" that we wish to see formulated in the minds of our children as they mature. For over and above our concern about the immediate insecurity and conflicted feelings of children whose parents are separated should be our equally great concern for a predictable constancy and stability in the love relationships of all people, one for the other.

THE RELATIONSHIP OF EMOTIONAL ADJUSTMENT AND INTELLECTUAL CAPACITY TO ACADEMIC ACHIEVEMENT OF COLLEGE STUDENTS

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IT is widely accepted that emotional adjustment and intellectual capacity are important factors in the academic adjustment and achievement of college students. In many instances the selection of college students is predicated upon their prior academic performance and indications of intellectual ability, with secondary consideration being given to their emotional stability. Attempts have been made to evaluate the importance of this latter factor in understanding the future performance of the student. Among them are Monroe's[7] study of women students at Sarah Lawrence College by the use of a modification of the Rorschach Test and the American College Entrance Examination. Jacobsen[5] evaluated the performance of medical students at Washington University School of Medicine using the results from the Minnesota Multiphasic Inventory as well as the Strong Vocational Inventory and Medical Aptitude Test.

These and other studies emphasize the importance and significance of emotional adjustment in the subsequent academic success of the student. However, an important criticism of the personality tests which have been used is that they appear to be uneconomical in time used for administering and scoring for continued use in accessing a large university population.

The purpose of this study is to investigate the relationship of emotional adjustment and intellectual capacity to the academic achievement of college students by using a relatively simple technique of testing and evaluation. The technique could be practical and useful to counselors or to the academic staff in identifying students who may show evidence of maladjustment in campus or classroom living. Another aim is to present results which may be used in forming selective criteria of the probable academic success of entering students.

Methodology

The subjects were divided into two groups who were selected at random from their classes. Group I consisted of 199 male members of the freshman class of Adelbert College. This was the entering class of 1948, which had a total of 297 members. A second group consisted of 154 female members of the freshman class of Flora Stone Mather College of Western Reserve University, also of the entering class of 1948 totaling 193 members. The Rotter Incomplete Sentence Test [10] was administered to all members of the sample and was used to give an indication of emotional adjustment.

The Yale Battery [4] and the American College Entrance Examination [2] were used routinely by Adelbert and Mather Colleges respectively to obtain an indication of the intellectual capacity of the entering students. The academic performance of members of the sample was followed for four years, and their entrance test scores were considered in the light of their subsequent academic achievement.

Criteria

The criterion of academic success was the attainment of a passing grade average of 1.0 at the first-year level. Graduation was the criterion of success used at the end of the fourth year in addition to the mean grade score for the class.

The Rotter Incomplete Sentence Blank is a projective technique which yields a numerical score indicative of gross personality conflict. It is not intended to provide ratings in finer diagnostic terms. This test is a revision of forms used by the United States Air Force in the selection of personnel; subsequently it has been used in clinical settings. The use of the incomplete sentence technique dates back to Ebbinghaus, who in 1893 utilized it to test intelligence in children. Subsequent use of this technique in the field of personality has been made by Tendler,[12] Rohde,[8] and Rotter.[10, 11] Comprehensive reviews of the historical development are presented by Abt and Bellak [1] and Bell.[3]

The Rotter ISB is made up of 40 separate items, each consisting of one or two stimulus words. The subject is required to add a sufficient number of words to complete a sentence, and by so doing provides, it is assumed, a reflection of his attitudes

and conflicts. The test requires approximately 30–45 minutes to administer and about 15 minutes to score, according to the manual based on a college population.

The Yale Battery and the American Council on Education Examination are recognized instruments yielding indications of intellectual capacity. These tests have been used routinely in the admission procedure of Western Reserve University.

Results and Evaluation

Correlations of Rotter Test scores and academic achievement for males and females at the end of the fourth year were .01 and .01 respectively. These correlations are in agreement with the findings of Rotter,[10] who states the general feeling that very little relationship seems to exist between intelligence and conflict scores. When related to grades the American Council on Education Examination yielded a correlation of .36. The Yale Battery yielded a correlation of .32 with grades. Because the Rotter correlations were so low, a regression equation approach to the data was not feasible. Scatter plots of the scores in various combinations revealed that the greatest variability occurred in the mid-ranges. Thus, a separate consideration of the quartile scores was thought to be valuable in addition to a study of the middle-range scores.

Initially, mean scores were obtained for all measures and used as cut-off scores. When the Rotter and Yale mean scores were considered separately in their relationship to academic success and failure by the Chi Square Method,[6] the Rotter scores lacked significance at the first- or fourth-year level. However, the Yale scores were significant, with correction for discontinuity, for the first year at the one percent level in distinguishing between passing or failing. But by the fourth year, the Yale score was less significant in reference to success or failure to graduate.

This raised the problem of identifying factors involved in the lowering of the significance of the Yale Battery score over the four-year period. To investigate the possibility that emotional factors influence the full use of intellectual ability the scores were considered together for each individual in our groups.

To gain information regarding these relationships the

Rotter and Yale mean scores were combined into four groups. When these combined groups were compared with Rotter and Yale scores alone, it was found that of the 15 students who were failing with Yale scores above the mean at the end of the first year, 10 had high conflict scores. Of those found to be below the mean Yale score, 59 were failing by the end of the first year, but here the Rotter score clearly did not differentiate between the groups. At the end of the fourth year in the high Yale group, of 24 who failed to graduate 14 were found to have high conflict Rotter scores. In the low Yale group, however, 43 failed to graduate and 20 out of 50 were found to have high conflict.

Thus, the Rotter adjustment score when combined with the Yale score may be of value in indicating failure in the group in the higher intellectual range. However, when the percentage total losses were evaluated no significant differences were found between the sub-groups. The results of the above suggested the importance of high intellectual ability upon academic achievement.

In order to discriminate further, the Rotter and Yale scores were divided into percentiles and compared with academic standings as shown in Tables 1 and 2. The 75th percent and 25th percent (representing the best and the poorest respectively) were used as cut-off scores; thus 50 percent of the sample were included in these groups.

As shown in Tables 1 and 2, the Rotter scores alone again did not differentiate between success and failure. The Yale scores, however, were significant at the first-year level and

TABLE 1.* ROTTER AND YALE PERCENTILES IN RELATION TO ACADEMIC STANDING IN FIRST YEAR OF COLLEGE. (MALE GROUP)

Academic Standing	*Rotter*			*Yale*			
	75%	25–75%	25%	75%	25–75%	25%	*Total*
Passed	31	53	41	47	58	20	125
Failed	18	33	23	7	37	30	74
Total	49	86	64	54	95	50	199
Percent loss.....	37	38	35	13	39	60	37

* The Rotter 75%, 25–75%, and 25% refer to low, moderate, and high conflict respectively. The corresponding Yale Battery 75%, 25–75%, and 25% refer to relative high, moderate, and low intellectual capacity for this group. (R 75% refers to scores of 121 and below; R 25% refers to scores of 137 and higher; Y 75% refers to scores of 380 and above; Y 25% refers to scores of 261 and below.

TABLE 2. ROTTER AND YALE PERCENTILES IN RELATION TO ACADEMIC STANDING, CUMULATIVE TOTALS FOR THE FOUR-YEAR PERIOD. (MALE GROUP)

Academic Standing	*Rotter*			*Yale*			
	75%	25–75%	25%	75%	25–75%	25%	*Total*
Passed	30	49	32	37	54	20	111
Transferred	3	9	9	8	9	4	21
Academic Loss: Failed	8	19	12	5	16	18	39
Withdrew ..	4	5	7	3	8	5	16
Military Service ...	4	4	4	1	8	3	12
Total	49	86	64	54	95	50	199
Percent loss.....	33	33	36	17	34	52	34

again by the end of the fourth year. The percentage losses were almost identical for both the first and fourth years.

The Rotter and Yale percentile scores were then combined and these groups compared on academic standings as shown in Tables 3 and 4. In these groups the more intelligent low conflict group (I-a) succeeded significantly better than the less intelligent high conflict group (III-c). At the end of the first year there were seven failures in range I, but six of these seven scored with some conflict or were highly maladjusted. In range III there were 30 failures, 22 of them scoring highly maladjusted or had some degree of conflict. In these combinations the students in the group of greater intelligence low conflict (I-a) were significantly more successful than those in the group of low intelligence and high conflict (III-c). Thus,

TABLE 3.* COMBINED ROTTER AND YALE PERCENTILE SCORES IN RELATION TO ACADEMIC STANDING AFTER FIRST YEAR IN COLLEGE. (MALE GROUP)

Academic Standing	*Yale I* Rotter #			*Yale II* Rotter			*Yale III* Rotter			*Total*
	a	b	c	a	b	c	a	b	c	
Passed	12	16	19	13	30	16	6	8	5	125
Failed	1	2	4	9	19	9	8	12	10	74
Total	13	18	23	22	49	25	14	20	15	199
Percent loss....	8	11	17	41	40	36	57	60	62	37

Significant at the 1% level of confidence.

* The Yale I, II, and III groups refer to the percentile divisions of Table 1 with Yale I indicating the higher intellectual capacity. The Ra, b, c categories refer to the Rotter percentiles of Table 1 with Ra indicating those with least conflict.

TABLE 4. COMBINED ROTTER AND YALE PERCENTILE SCORES IN RELATION TO ACADEMIC STANDING, CUMULATIVE TOTALS FOR THE FOUR-YEAR PERIOD. (MALE GROUP)

Academic Standing		Military *Yale I* Rotter #			*Yale II* Rotter			*Yale III* Rotter			*Total*
		a	b	c	a	b	c	a	b	c	
Passed		12	12	13	12	31	12	6	7	6	111
Transferred ...		0	4	4	3	3	3	0	2	2	21
Academic Loss	Failed ...	0	1	4	5	8	3	3	10	5	39
	Withdrew .	0	1	2	1	4	3	3	0	2	16
	Military Service..	1	0	0	1	3	4	2	1	0	12
Total		13	18	23	22	49	25	14	20	15	199
Percent loss....		8	11	26	32	31	40	57	55	47	34

Significant at the 1% level of confidence.

in range I, group "a" is most successful but this does not follow for the "a" group in the other ranges. However, this may be fortuitous because of the small number in our sample.

By the end of the fourth year, the results were substantially the same. The Rotter appeared to be most useful in range I in distinguishing between the groups, since in group I-a there was only eight percent loss as compared to 26 percent loss in group I-c. The percentage of academic loss increased from the first year to the fourth year in groups I-c and II-c. Thus, it would appear that the Rotter scores were of value in indicating the impact of emotional conflict upon academic achievement when viewed in combination with intelligence in this highest range. In ranges II and III the Rotter score did not discriminate between the groups. Within range I the Rotter scores were able to distinguish between the groups and indicated a consistent progression of loss from I-a to I-c at both the first and fourth year. Further, the percentage loss in group I-c increased by the fourth year from 17 percent loss to 26 percent loss.

Additional information was obtained when the mean of the grade point average was matched against the Yale and Rotter percentile scores as shown in Tables 5 and 6. When this was

TABLE 5. COMBINED ROTTER AND YALE PERCENTILES IN RELATION TO MEAN POINT AVERAGE FOR FIRST YEAR IN COLLEGE. (MALE GROUP)

Academic Standing	*Yale I* Rotter *			*Yale II* Rotter			*Yale III* Rotter *			*Total*
	a	b	c	a	b	c	a	b	c	
Above Mean....	12	14	15	9	22	11	1	2	3	89
Below Mean....	1	4	8	13	27	14	13	18	12	110
Total	13	18	23	22	49	25	14	20	15	199

* Significant at the 1% level of confidence.

done, the significant finding was that the groups in range I still differed. At the end of the first year, in range I, 41 students out of 54 obtained grades above the mean; in range II, 42 out of 96 scored above the mean; in range III, only six out of 49 scored grades above the mean. This would indicate the effect of intellectual capacity in academic performance. In range I, group I-a (low conflict) had only one student with a score below the mean, while in group I-c (high conflict) there were eight students below the mean. This seems to support the above results that the Rotter is of value in discriminating loss in the higher intellectual level.

TABLE 6. COMBINED ROTTER AND YALE PERCENTILES IN RELATION TO MEAN POINT AVERAGE, CUMULATIVE TOTALS FOR THE FOUR-YEAR PERIOD. (MALE GROUP)

Academic Standing		*Yale I* Rotter			*Yale II* Rotter			*Yale III* Rotter			*Sub-total*	*Total*
		a	b	c	a	b	c	a	b	c		
	A	9	10	11	4	11	4	0	1	1	51	
Passed	B	3	2	2	8	20	8	6	6	5	60	111
Academic Loss: Failed...	A	0	0	0	0	1	0	0	0	0	1	
	B	0	1	4	5	7	3	3	10	5	38	39
Withdrew	A	0	0	1	0	0	1	0	0	0	2	
	B	0	1	1	1	4	2	3	0	2	14	16
Trans-ferred.	A	0	2	3	0	0	2	0	0	0	7	
	B	0	2	1	3	3	1	0	2	2	14	21
Military Service	A	0	0	0	0	1	1	0	0	0	2	
	B	1	0	0	1	2	3	2	1	0	10	12
Sub-Total	A	9	12	15	4	13	8	0	1	1	63	
	B	4	6	8	18	36	17	14	19	14	136	199
Total		13	18	23	22	49	25	14	20	15		199

See Tables 3 and 4 for explanation of terms.
A—above mean grade point average.
B—below mean grade point average.

At the end of the fourth year, the results appeared to follow the same trend, as indicated in Table 6. In range I, the differences between the groups above and below the mean (A and B respectively) were found to be not statistically significant. In the category of academic loss, group I-a lost only one—and that student to military service. Group I-c, in contrast, had ten students who were lost to the school for various reasons. In ranges II and III only chance differences were found. Characteristically, those who failed to graduate by and large achieved grades below the mean point average. In the transfer group seven (33⅓ percent) scored above the mean for the class, but the majority of these were located in range I.

TABLE 7. COMBINED ROTTER AND YALE PERCENTILE SCORES IN RELATION TO FAILURES PER SCHOOL YEAR. (MALE GROUP)

School Year	*Yale I* Rotter			*Yale II* Rotter			*Yale III* Rotter			*Total*
	a	b	c	a	b	c	a	b	c	
1st	0	1	0	1	1	2	0	5	2	12
2nd	0	0	2	1	2	1	2	3	1	12
3rd	0	0	1	2	5	0	0	1	0	9
4th	0	0	1	1	0	0	0	2	2	6
Total	0	1	4	5	8	3	2	11	5	39

See Table 3 for explanation of terms.

This would lend credence to the view that some highly endowed students may transfer to other schools offering more personal opportunity. Among the 21 transfers only 3 students were found in the "a" groups (Table 6). This trend holds up in an examination of the other academic categories of loss where fewer students were found to be in the "a" (low conflict) category. Also, those students who left school for various reasons by and large are those who had grades below the mean point average.

Analysis of the failures over a four-year period (Table 7) revealed that the greatest number of failures (24) occurred within the first two years of college. In range I only one student failed at the end of the first year who falls in group I-b. The other failures occurred in group I-c during the remaining three years. Significantly, there were no failures in this range of those who were adequately adjusted (I-a). In range II, five failures in 16 occurred in group II-a. All the failures

in group II-c failed by the end of the second year, while those in groups II-a and II-b managed to stay in school for a longer period before dropping out. Findings in range III show that the more adequately adjusted group had two of the total of 18 failures. Again, the greatest number of failures occurred within the first two years. Summarizing the failures, only seven out of 39 (18 percent) were adequately adjusted in contrast to the remaining 32 (79 percent) who had some degree of conflict; moreover, of the total of 39 failures 31 percent had what was considered a high degree of conflict.

From the above findings with the male group, the most pertinent data seems to be obtained from the percentile groupings. The most successful group of students was that scoring both with high intelligence and low conflict. In the category of academic failure the smallest loss appears in the adjusted groups, which is also found to be true in the transfer and withdrawal categories. Delineating the above groups of well-adjusted students for selection to college does not imply exclusion of all other students from admission, but rather the identification of those who would profit from some additional assistance in order to better benefit from their academic experience. Such help could be forthcoming from faculty advisers, a counseling service, and psychiatric consultation.

The female group scores were arranged in the same manner as discussed above. Comparison of the Rotter and the American Council on Education Examination mean scores with academic success and failure showed no statistically significant difference for the Rotter scores. This was the same finding as obtained in the men's group. When the combined scores were used, the Rotter was able to distinguish between success and failure among those students who scored in the lower intellectual range. There were two and one-half times as many failures at the end of the first year of those who achieved Rotter scores indicating conflict. However, at the first-year level there was no distinction between the high intelligence groups.

At the end of the fourth year, the groups with better adjustment met with greater achievement than those with poor adjustment within the entire range of the intelligence score.

The percentile combinations were considered as in the male group (Tables 8 and 9). The results at the end of the first

TABLE 8.* COMBINED ROTTER AND A.C.E. PERCENTILE SCORES IN RELATION TO ACADEMIC STANDING AFTER FIRST YEAR OF COLLEGE. (FEMALE GROUP)

Academic Standing	*ACE I* Rotter			*ACE II* Rotter			*ACE III* Rotter			*Total*
	a	b	c	a	b	c	a	b	c	
Passed	7	13	11	25	35	19	5	7	2	124
Failed	1	1	1	4	5	7	0	10	1	30
Total	8	14	12	29	40	26	5	17	3	154
Percent loss....	13	7	8	14	13	27	0	59	33	19

* ACE groups I, II, and III refer to the relative intellectual capacity of the sample with ACE I including scores at the 75%, or 140 and higher; ACE III refers to the 25% lower group with scores of below 102; ACE II includes all in the middle range. The Rotter a, b, and c groups are the similar percentile levels with Ra having scores of low conflict, those below 112. Rc includes high conflict scores of greater than 140.

year were inconclusive. However, the well-adjusted higher intelligence group did consistently better than all other groups within the ranges by the fourth year. The well-adjusted group in each range did better than all other groups. Although there were fewer students in the female group, the trend seemed to be similar to that found in the male group. Also, there were fewer well-adjusted students among those who failed to graduate. Thus, the Rotter adjustment score seemed to be able to indicate those students who would be likely to have difficulties and thus provides an opportunity to identify and assist them.

In Table 10, the failures in the female group were consid-

TABLE 9. COMBINED ROTTER AND A.C.E. PERCENTILE SCORES IN RELATION TO ACADEMIC STANDING, CUMULATIVE TOTALS FOR THE FOUR-YEAR PERIOD. (FEMALE GROUP)

Academic Standing		*ACE I* Rotter #			*ACE II* Rotter			*ACE III* Rotter #			*Total*
		a	b	c	a	b	c	a	b	c	
Passed		4	6	6	20	23	13	2	7	1	82
Transferred ...		3	1	1	3	11	3	2	4	0	28
Academic Loss	Failed..	0	1	1	1	3	4	0	4	1	15
	Withdrew..	1	6	4	5	3	6	1	2	1	29
Total		8	14	12	29	40	26	5	17	3	154
Percent loss....		13	50	42	21	15	38	20	35	66	28

Significant at the 1% level of confidence.

TABLE 10. COMBINED ROTTER AND A.C.E. PERCENTILE SCORES IN RELATION TO FAILURES PER SCHOOL YEAR. (FEMALE GROUP)

School Year	*ACE I* Rotter			*ACE II* Rotter			*ACE III* Rotter			*Total*
	a	b	c	a	b	c	a	b	c	
1st	0	0	1	0	2	3	0	3	1	10
2nd	0	0	0	1	1	1	0	1	0	4
3rd	0	1	0	0	0	0	0	0	0	1
4th	0	0	0	0	0	0	0	0	0	0
Total	0	1	1	1	3	4	0	4	1	15

See Table 8 for explanation of terms.

ered. Here there was only one failure in an individual with good adjustment. Forty percent, or six out of 15, occurred in individuals with a greater degree of conflict. The majority of failures again occurred at the end of the second year. Thus, the trend of failures occurring in those individuals with emotional maladjustment is the same as seen in the male student group.

Summary

The Rotter Incomplete Sentence Blank along with two measures of intellectual capacity were administered to 199 males and 154 females, all of them students of Western Reserve University. The tests were given in their first year at school and compared with grades achieved at the end of the first and fourth years.

Correlations of the grades and test scores were low and scatter plots revealed greatest variability in the middle ranges. Conclusions were derived by analyzing the relationship between the percentile test scores and academic grades achieved at the end of the first and fourth year.

The study seems to bear out the general assumption that students with high intellectual capacity and an adequate personality adjustment achieve higher academic performance. Those students who indicate deficiencies may be observed from the onset of their college careers and given the benefit of additional counseling, if necessary, as indicated by their first year grades and test scores.

Because failure in the first year seems to parallel fourth-year performance, the importance of early counseling should not be minimized. The well-adjusted groups in all ranges—

particularly in the highest intellectual range—do better academically than those with conflict. In terms of selection for college, since the lower 25 percent is not as promising a group as the others perhaps fewer in this range should be selected. Within the upper ranges of intelligence the better adjusted student faces less likelihood of subsequent failure.

Consideration of the combined tests is of value in discerning students of good intelligence and high conflict who will not profit from their college experience as much as those with a better degree of adjustment. The possibility of helping these students capable of academic success is increased by this recognition. Awareness of the presence of highly endowed students who are likely to have difficulty because of emotional maladjustment provides an opportunity for faculty advisers to assist them.

In the remaining ranges of intelligence less difference is seen between the groups, but there seems to be some tendency towards better performance in those with better adjustment. This was seen more prominently in the female group and seems to be better borne out in the analysis of failures, withdrawals, and transfers. Here it was seen that there are fewer adequately adjusted students in these categories. The study further emphasized the importance of intelligence as the factor bearing the greatest weight upon future academic success.

The value of recognizing that emotional factors in students contribute to failure or academic loss is certainly apparent, and it is sound economy to employ measures to diminish this loss. This is important not only because of the financial investment made by the school, but also because of the loss to the community of those who may be potentially more valuable for having completed their college training.

It should be emphasized that selection for admission to college in itself is not the primary aim of this study. The study also provides a measure to indicate the potentially maladjusted students. These should be provided with proper guidance so that they may be able to continue successfully in school. This would be especially applicable to students who are meeting with failure or who are not realizing their intellectual potential to the fullest extent.

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THE TRIALS OF NORMALCY

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SINCE Clifford Beers first wrote *A Mind That Found Itself,* that classic and original best seller among the psychiatric autobiographies, we have been largely concerned with the mentally ill. That has been all to the good. For in many ways the care of the mentally sick was miserably inadequate, and in numerous respects quite disgraceful. During all this time, however, the vastly greater portion of our population, the so-called normals, if not entirely neglected, has been overlooked. It is true we have had a mental hygiene movement which concerned itself with mental health as well as with mental illness. But for all its valiant efforts, its effects have not been great. For most of us seem to operate in the belief that when you are sick something should be done about it, and quickly too. But when you're normal, why that's all there is to it.

Now let us agree that you *are* normal. Can you then take it for granted that life will always run smoothly for you and that you and yours may properly expect, as the fairy tale phrases it, to live happily forever after?

Naive as this may seem, quite a number among us, especially the younger ones, entertain just such expectations. As a result, when things do go wrong, we are astonished, bewildered, and hurt. We are prone to feel that life has been unfair to us. But the crucial trouble is not with life but rather with us, in that we think only the mentally ill have problems. In fact, however, all of us do. Normal people have normal problems, in normal experience. That needs to be underscored many times over. And furthermore we need to understand what these problems are likely to be, when they are prone to arise, why they come into being, and how we can best deal with them. But above all we need to understand that normal people, in normal experience, do have normal problems. Why stress this so much? Because we have long been the victims of a foolish fiction. We have had a romantic, unrealistic vision of normal life as an untroubled, smooth-sailing voyage on the high seas

of experience. But that's nonsense! Nothing in reality supports this picture—foisted on mankind by the sickly, juvenile, French romanticist Jean Jacques Rousseau. It was he who gave rise to the fiction of the "noble savage," and it was he who enthusiastically and persuasively preached the corrupting sermon of a sweet and reasonable naturalism. Others after him took up his roseate beliefs and compounded them into a completely false scheme of life. Life, they argued, is inherently logical, reasonable, smooth, harmonious. It should unfold as untroubled and untroubling as the sweet breath of the gentle spring. It is not life that troubles man, they insist, but man that troubles life. Many among us have been taken in by this wishful thinking, propounded by a sensitive and gifted genius who, unable to face up to the actualities of the living experience, fictionally reshaped the scheme of things closer to his heart's desire. But wishful thinking little affects the reality. And the reality reveals that the living experience affords us great adventures, all of which, however, are beset with many problems.

We come into this world in a turmoil of strife. Some psychiatrists make a great deal of the adventure of being born. They refer to it as the *birth trauma,* and trace to the travail of being dispossessed from the sheltered confines of the womb many of the emotional disaffections of later life. Being born *is* a trying job, no less for the infant than for his mother in labor. But one need not go to the extreme of swallowing whole the fine-spun theories of the birth trauma. On the contrary one can fancy that during the last months of pregnancy the fœtus would find its quarters rather cramped, and thus would be eager to get out where it might stretch a bit. But however one may fancy the adventure of being born, it is certainly not free of problems. Nor does it end on delivery. On the contrary, every step thereafter in the complicated process of growing up confronts the individual with numerous challenges and a variety of problems. For, inherently, growing up, and the living process in general, cannot be pictured as a smooth line of progression, following a wave-like pattern. Actually it is full of reversals, of contradictions, and diversions. It is zigzag rather than smooth. Its logic and pattern is over-all, rather than manifest in each step. Think of the infant driven out of its Garden of Eden, the womb, into the strange and be-

wildering world of the multiform sensations. Before it can become reconciled to its loss there comes upon it the awareness of its mother, a strange person, but soft and warm and pleasing in a variety of ways. The world which first assaulted it with its harsh textures, its unyielding hardness, its noises, bright lights, and changing temperatures, soon yields most interesting patterns. Faces in time take shape, and generally they are smiling, benevolent faces, faces which induce and call forth smiles and gurgles. Touch, too, somehow is molded into caresses and meaningful movements. Strong hands handle you and accomplish wished-for changes. And thus, in many ways, life beyond the womb proves pleasant and rewarding, and the Garden of Eden is almost forgotten. The future, if the infant has any but an indwelling awareness of things to come, must seem to it assured and lovely. But then the adventure is diverted by the advent of unanticipated and most often unpleasant experiences. We can not count them all, but there is solid food in the place of the warm flowing nourishment, toilet training, the seemingly foolish impulsion to stand up, which yields only bumps and bruises, sharp edges that cut, heat that burns, and so on. Worst of all, and all too soon, that creature known as mother, she whom we have come to love more almost than our own sweet selves—she betrays us. The love and attention that she bestowed upon us, that surely was ours by right, she now bestows upon others. The usurper may be that overwhelming creature we thought to be our friend, and whom we heard called father. Or worse still, because it is usually preceded by a mysterious and gradual withdrawing, capped by an inexplicable disappearance of our beloved—the usurper may be a tiny, ugly, squeaking creature that for God-knows-what reason our mother has brought back to live with us. Ugh!

The sophisticated will recognize in this hasty sketch of the infant's adventures the advent of two trying problems—that of the Œdipal complex, and that of sibling rivalry—both, be it noted, normal problems in normal experience. Our intent, however, is not to trace here the full pattern of the individual's adventures in the living process, but rather to underscore the fact that those adventures are not consistent nor logical, but involve rather sharp changes and abrupt reversals. As we go on from one stage of life to the next there are always new

things to be learned and old ones to be unlearned. The latter is all too often the harder task.

Freud has described the young child as a polymorphous perverse creature. The child is in fact natively uninhibited and unashamed. That it might live in and be accepted by society it must be taught to control its impulsions, to curb its curiosities, and to defer its gratifications. But then when it comes of age, the child, grown man or woman, must unlearn the lessons of its childhood, must know that what was heretofore disallowed is now permitted, that what in time past was deferred may now be fulfilled, that what was in such devious ways and for so long repressed must now be realized. Unfortunately, far too many cannot entirely unlearn the lessons of their childhood, and their adult lives are haunted and frustrated by the taboos and inhibitions acquired in childhood.

Here again romanticism rears its befuddled head, for some, who have seen the trials of those who could not meet the demands of adult relations, have resolved to spare their children the risks of such failures by imposing upon them few restrictions and few inhibitions. In most instances this results only in a "jumping out of the frying pan into the fire." As any psychiatrist of experience can attest, the uninhibited neurotic is the most difficult to treat and to help.

The logic of the situation calls neither for crushing repressions nor for uninhibited freedom. What is needed is doing the immediately necessary with an eye to the future reversal. This is a pat phrase, the meaning of which is not easily grasped. Yet that is precisely what is reflected in the affirmation that normal individuals normally confront normal problems in normal experience. All this is best expounded in terms of actual life situations. Let us consider the adventure of falling in love and marrying. Here is a strictly personal experience rooted in one's innermost emotions. The average person in love not only surrenders to the feelings of love, but does so without the least doubt or misgiving but that "as it is now so will it be forever and anon." Of course there are the cynics and the doubters. But for the moment let us exclude them from our deliberations. Besides, most of them are cynics and doubters not because they are wiser but rather because they have imbibed the vinegar of frustration rather than the sweet wine of romance. Now, it is most desirable that those in love

should yield wholeheartedly to their gentle madness. But somewhere in their intoxicated spirit there should be present a sober and rational iota to warn them that love is the beginning of greater things to come and not an end in itself. Unless this sober iota is present and effective—ahead lies trouble. Far worse than too brief a honeymoon is one that outlasts its normal span. The individual, man or woman, who seeks to linger and will not get on with the adventure of living courts disaster. Yet assuredly the most certain, the most unquestionable, persuasion of the lover's heart is that he loves his sweetheart and wants her, for herself, for himself. He has but little awareness that behind this so personal and so intimate emotion there operates a transcending purpose, that of bringing new life into being. Yet sooner or later he, and she, too (though it is easier for her since she has an intuitional awareness of the meaning of all this seldom given the male), must face up to the fact that the private love which enticed and bound the twain must be extended to embrace children, friends, the community, and, ultimately, society. Here too we have come upon a host of normal problems in normal experience. It is no easy task to surrender the woman one loves even to one's infant son or daughter, nor to do with less of service, comfort, attention, leisure, and privacy than one had learned to expect. It is no whit easier for the woman to learn the art of serving two masters at once, and of appeasing the demands of two so very self-centered beings as an infant child and a jealous husband. And then just about the time when a balance of powers has been established and a familial *entente cordiale* created, the hard-won equilibrium is likely to be disturbed by a new arrival. And how, pray, do you do justice to the new without doing injury to the old? The first child is a challenge, the second also, and so is the third and the fourth —each in its own and rather unique way. If their arrival creates problems, so does their growing up, and their trial flights, as they sprout their wings in preparation for taking off on their own.

These are the rewarding adventures of fruitful living. But they bring in their wake a host of problems: the normal problems in the normal experiences of normal people. They should be expected, anticipated, understood, and mastered. All this implies a knowledge of what might be termed the psycho-

physiology of normal experience. It differs from psychopathology, which deals with the diseases and disturbances of the psyche. In some ways it differs also from mental hygiene, for hygiene has traditionally concerned itself with the prevention of disease.

The psychophysiology of normal experience implies something more subtle and yet more fundamental. It bears on the better and fuller living of life. It suggests a degree of insight and sophistication which should enable one to yield to the immediate adventure in experience and yet not to be taken in by its blandishments. Off in the not-too-remote future one should perceive the inevitable change, and be ready to meet it without, however, compromising the present, or dampening the enjoyments thereof.

Is this then a new art to be mastered, a new wisdom to be gained—this psychophysiology of normal experience? In some ways, yes, though historically it is an ancient art, and an ancient wisdom. The best, and in many ways the most fitting, analogy to the psychophysiology of normal experience, is the recently developed science of nutrition. Nutrition also was an ancient science. Hippocrates, the great physician of ancient Greece, traces the origin of medicine to the study of foods, to the observations of which nutriments favor health and which are debilitating, which relieve certain symptoms and which aggravate them. But the science of modern nutrition is radically different from that envisaged by Hippocrates, and part of the reason for that derives from the difference in our foods and in our food habits. The world in the times of Hippocrates, and for many centuries thereafter, was and remained simple. Most of mankind lived "off the earth." Foods were not preserved, stored, refined, and in general treated as we today do and must treat ours. Let me not be misunderstood. The average individual in our part of the world is far better nourished than ever was the ancient Greek citizen or slave. But to be better nourished our people need not only the foods available but the guidance also of the science of nutrition. Such, too, is the case with what we have termed the psychophysiology of normal experience. When families lived in homesteads, with three or more generations in close proximity, the very experience of living together was profoundly instructive. One did not require a course in domes-

tic science, home economics, or child care to prepare for domesticity. One learned that, as one acquired one's mother tongue —by exposure and functional practice. One also acquired insight, wisdom, one might say, as well as knowledge; for one had before one's very eyes a panorama of life in all its stages. But the homestead is gone, and fortunate are the generations that live within phone-call distance of each other. The structure of the family has changed most radically. Neither the position of the woman, nor that of the man, nor that of the child, is what it had been even three generations ago. The woman has been radically dislocated in the familial scheme, but the child even more so. Time past, as soon as the youngster had the requisite strength it was assigned its chores. Thereby it acquired not only a sense of functional belonging, but also some insight into what is involved in keeping the family going. Nowadays for many youngsters, especially for those living in cities, there are no chores to perform; at best there are errands.

The social scientists are much concerned with these problems, and to them we must leave the more special exposition of them. Here we need only call them in witness of the need for an understanding of the normal problems of the normal individual in normal experience. For even if you are normal (and why should we assume anything else?) you will have your problems to face and to resolve, and you will do that more effectively the better you understand them.

THE PATIENT IN A HOSPITAL SETTING

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THE study and evaluation of the patient in a hospital setting can be fully appreciated only as the home is better understood. Since getting the patient well is the all-important function of the hospital, it was thought advisable to study such a home situation so as to use this data in his recovery program.

From the cases known to us, an average patient who was ill enough to be hospitalized was studied. This patient accepted his illness, believed with time and care he could easily get well, and saw no reason to be transferred to a hospital. He felt he was giving up too much to go to any hospital: he was among his loved ones; their smiles, their actions showed respect and reverence for his every wish. He found when he was ill he got even more consideration than any kindness he might have conferred on his family; there was, therefore, every temptation to stay ill so as to be the recipient of the many favors which members of the family might vie with each other to give. This feature he shared with no one as he would have to do in a hospital. His bed was his own, he felt comfortable there, and there were many little things around the house he could still use as he saw fit. All these made hospitalization less inviting. If he went to the hospital, he would have to get another doctor to whom to relate his illness, and even then he did not think he would feel free to discuss everything to a stranger. He had extreme confidence in his physician and, while he respected his doctor's concern for his health, there was a secret feeling that either the doctor underestimated his own ability to help him or just wanted to be rid of him. He could also foresee being among other people whose conversations about their illnesses might force him to think more about his own illness and thus increase his worry.

Studies carried out by nurses and house staff through the years completely enabled us to meet these objections. The patient was assured by his own doctor that he would be visited whenever he so desired and that the doctor-patient relation-

ship *per se* would not be interrupted but rather enlarged for a while. The nurse who first met the patient and his family warmly greeted them. She gave assurance to the family and the patient separately that every effort would be made to make him comfortable and cheerful during his stay in the hospital. The nurse in turn talked to the family to get a bird's-eye view of the idiosyncrasies of the patient so as to understand him all the better.

Placing the patient in the right bed on a ward is always a difficult task. The nurse from her knowledge of her ward community tried to put the patient beside two other patients with whom he could get along easily. The patient was next introduced to his bed neighbors so as to make his area as cheerful as possible. Since patients often request changes, the resident in conjunction with the head nurse may decide that removal to another area may be to the best interest of the ward community. This patient was no exception; he soon developed a great dislike for one of the patients beside him, and at his request was removed to another area. He nevertheless maintained a very close association with the other patient who formerly occupied the other bed beside him. He found his new area more to his liking, closer to the bathroom and to the radio — features he enjoyed at home.

To assure the patient of privacy when he so desired he was advised he could use the curtains around his bed at any time.

A nurse is assigned to several patients and the same is true of the house staff. The patient thus gets the feeling he has his own nurse and his own doctor, in spite of the fact that the doctor and nurse may administer the entire ward. In addition, this helps in arranging programs and carrying out social contacts that would hardly be possible otherwise. Such was the situation to which the patient was subjected.

The patient was also questioned daily not only about his illness, but about any situations that might occur that would make hospitalization unpleasant or pleasant. Doing this prevented him from building up prejudices. At the same time, the nurse explained the ward rules, and explained why when many people live together it is necessary to establish rules for the common good of all. Acceptance of this was much easier than anticipated.

Food was a difficult problem, since at home anything desired

could be had. In the hospital pattern this was not so. Nevertheless, logical explanations were given as to the need for a balanced diet, as we know it, in terms of carbohydrates, proteins, and fats. This too was accepted without difficulty. Soon there was little concern about diet. The fact that he could get some of the things he specially wanted made the problem all the easier.

The patient was in the habit of talking to his doctor about his medications, about what they were for and what was expected. This explanation was offered even before the patient could bring up the question. He was thus happy to be so treated, and felt he was participating in his own therapy. The patient was also prepared for psychotherapy by being told of its aims and purposes and how it was very necessary for him to cooperate. The fact that he was treated in this manner made him all the more willing to discuss his problems with his physician. The opportunity to talk out his problems, to mix with others in group therapy, to be able to relax and play games with others, and to have sympathetic care and understanding from the nurse at the bedside, or her willingness to listen or be a big sister, all helped in his total push for recovery.

As the patient was speeded towards recovery, the family was brought back more fully into the situation so as to be prepared to accept the patient. The patient was also prepared to meet his family again. This was done by physician, social worker, and nurse as a team, each carrying out a specific task. When through conferences the task was considered completed, the patient was once more discharged to his family and his community.

Before discharge, the patient was asked by the head nurse to register any complaint he might have. His only comment was that he was never better treated anywhere. He expressed a desire for periods of seclusion just to think. It was pointed out that in a psychiatric setting this was not always possible unless the patient was advanced to the point of discharge, and then he would scarcely want to be alone. It was nevertheless felt that something deeper was behind this statement: the patient wanted to be allowed to think through in silence certain situations in therapy. The seclusion room was suggested as such a place, but this only partially met such a need.

The patient reported that he missed home only the first few days and that the nurses took over so completely that he was thus in the best of mood when his physician came to assist him.

In all he regarded hospitalization as a most wonderful experience.

Comment

The task of treating the mental patient as a person means marshaling around him all the social forces so as to give him a lift and thus build up ego strength. This factor and its relation to illness has been very well noted by Alexander.[1] The importance of the nurse in this setting cannot be overstressed, for as Lapham[2] has pointed out: "She is with the patient for hours on end." He has pointed out also that all too often a nurse is called from the case after a day because of incompatibility of personalities; our observations bear out this experience. Good nursing care greatly enhances recovery from every angle.

The importance of team-work and the participation of attendants in team-work is an essential feature in the care of these patients. This was noted by Anderson[3] who believed that in some way skill noted at these levels should be passed on to the highest nursing level.

Bennett and Eaton[4] have noted the tremendous value of the nurse in the new therapies, a rôle which we have observed as nurses are given this opportunity, and a point also expressed by Dix[5] and Mellow.[6] It was observed that when the ward was stable and the patients occupied or allowed to mix freely, the rate of improvement seemed greater than when the ward frequently became upset. The desire to keep a quiet and stable ward definitely promoted recovery. This has been noted by Boyd[7] and Greenblatt.[8]

Finally, there is the task of returning the patient to his home. The method of terminating his care is most important if the patient is not to feel he is no longer wanted. There must be general acceptance that the patient has been given maximum care and that he can now be discharged. This has been stressed by Lorand[9] and Stekel[10] and borne out by our own experience.

In our setting, therefore, we try to reproduce as well as possible psychological, emotional, and to some degree physical features familiar to the patient so that his transfer from home to hospital is minimally traumatic. It is our experience that such an atmosphere — created by a team of doctor, social worker, nurse, psychologist, and attendant — permits a greater and a more rapid recovery of the mentally ill, and makes the follow-up immeasurably easier. Knowledge of the home, therefore, proves to be of great value, not only in managing the individual case but in handling various cases in an open ward. This attempt to treat a person who is ill, rather than a disease, not only helps the patient but shows all who participate in this care the great interdependence of services and the value of a team in the hospital.

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SILENT PARTNER IN MENTAL HEALTH *

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PERHAPS you know that the growth of mental hygiene, at times a saga of glory and human greatness, is more frequently written in man's blood and suffering. We are so accustomed today to enjoy a democratic way of life, in which human life and dignity are given high valuation, that we may tend to forget the centuries of stigmatization, torture, derision, and neglect to which human emotional problems were exposed. It may be difficult for us to realize that the release of the mentally ill from chains, their care in fine institutions, and the advent of effective systems of treatment are matters of comparative recency.

One need only examine within himself the human tendency to conform closely to a prevalent attitude of a particular time in civilization's history to realize the heroic steadfastness, the foresightedness, the self-effacement, of those intrepid men and women who fought bravely and successfully to bring to our culture realization of the human ethical principles concerning man's humanity to man. The greats of history are not those whose performances lay within the sphere of prescribed and formulated patterns of behavior; the greats have been the dedicated souls who have seen beyond the obligations of a particular moment, who have been gifted with sympathy and understanding for their fellow men, and who have possessed a quiet genius capable of visualizing a social panorama projected into a future in which the welfare of man is a way of life.

The development of the mental hygiene movement follows a pattern not unlike that seen in other areas of human service. We all know that the skilled, technically competent, and highly

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qualified physician of today evolved from the superstitious, ignorant, and often brutal barber of many years ago. The very able, beloved, and well trained nurse of this day represents a tremendous advance in development from the socially unaccepted and unrecognized camp-follower of days gone by.

I believe we are witnessing today a stage in the progress and advancement of another profession. From what once was described as a motley crew of people of questionable social adjustment who chose to care for the mentally ill not through talent but through necessity, we are now seeing in ever-increasing numbers the emergence of highly competent stalwarts like the men we are privileged to honor today. Coming from out of a barren and ignominious past such men and women pave the way for those who must follow after them into the relatively uncharted territory of non-professional psychiatric services to the emotionally needy. These men and women are the Columbuses, Balboas, and Rogers and Clarks of the mental hospital wards. They are map-makers, creators of standards, and leaders in the formation of social ideals.

These are the men and women, sickened by glimpses into the past, who develop and exemplify modes of human relationship that will brighten the future.

It may be well at this juncture to consider for a few moments the importance of the psychiatric aide in the overall treatment program of mental institutions. Of late we have heard so much about the value of "miracle drugs" and of penetrating and effective psychotherapies which are in use in all enlightened institutions that we are inclined to conclude that the only important work contributing to the recovery and well-being of psychiatric patients is that done by the professional members of the staff—the doctors, nurses, psychologists, and social workers. There is no question, of course, of the importance of their work. We know that man's most profound comprehensions of the human psychological structure and the capacity to change it in its unhealthy aspects are scientific acquisitions of less than three-quarters of a century. We know that the physical therapies that require the close cooperation of the physician and the nurse are of inestimable value in the welfare of the many thousands of people who have had, are now suffering from, or will develop mental disorder. We are inclined to think that the magic

therapeutic agent applied at the flood tide of opportunity manages of itself, in a few moments of the patient's life, to promote enduring and desirable changes.

In actuality the true picture of therapy of the mentally ill within the hospital is quite different. The contact of the physician and even the nurse with the patient is an all-too-short and fleeting experience to him. This is owing in part to the well known shortage of psychiatric personnel and the excessive demands on their time. But the real follow-up care, the real ongoing and continuous personal relationships with patients that exploit for the good the momentary treatment efforts by professional personnel, are in the province of the daily activities of the psychiatric aides.

Of course, just as these may be forces for good, sometimes they may be forces for evil. The work of professional personnel may at times be undone by attendant personnel who are disinterested, indifferent, or malevolent toward the patient and his problems. In such cases the fine work of professional personnel may be reversed. This may, in some instances, account for certain therapeutic failures.

In great measure the psychiatric aide must maintain and extend the therapeutic gains achieved by the psychiatrist, nurse, and co-workers. The aide remains in intimate contact with patients. He serves them. He is their companion. He may be the recipient of their tales of woe or the target for their anger. Whatever the particular emotional needs of the patients, the aide is expected to meet them. We often speak of the work of the aides as ancillary or adjunctive in a psychiatric program. I think we may find that in a very large number of instances the aide is the primary therapeutic agent, and he can be a highly significant influence in the lives of his charges.

What is the psychiatric aide? First of all he is *a member of the community.* He is a representative of the social environment from which all too often the mental hospital has become isolated, both by walls of brick and mortar and walls of prejudice and stigma. The aide brings into the ward with him the philosophy of the external society. If the aide is an individual with good character and at least adequate personal attainment, he is a beneficent influence in the ward. He is the "normal contact" for the patient. He is the guidepost,

the "average," the example. In order that the gap between the tormenting isolation of mental illness and the (hopefully) anxiety-free return to social living be bridged, the aide must be that cohesive force and arbitrator that resolves differences and makes social reintegration attractive.

The psychiatric aide is *an individual with specialized experience.* The countless events in the daily lives of patients constitute a set of ever-renewed emergencies. The capacity to meet such emergencies is partly based on the natural endowment of the aide. To a large extent he must exercise a quality of human judgment which renders him a potent force toward the emotional well-being of patients. The integration of his multitude of experiences into his own personal growth develops in the psychiatric aide a technically skilled person especially prepared to meet, deftly and judiciously, patients' urgent problems.

The psychiatric aide is *an indispensable gear in the machinery of a mental health program.* The final implementation of therapeutic systems and the application in great detail of the countless important little elements of living are in the hands of the aide who is in direct contact with patients. An entire therapeutic program can be almost meaningless without the aide through whom interpretations are mediated. He contributes to the comfort of patients, notes the effects of the different therapies, translates into understandable daily experience the therapeutic intentions of the institution, and serves as the connecting link between the patient on the one hand and the planners on the other.

The psychiatric aide must be *a person of considerable courage.* To come into the wards of a mental institution carrying with oneself the preconceptions and prejudices of the community and to consciously stifle the anxieties and fears that they generate in order to accomplish assigned tasks require an intrepidity which is often heroic although unpublicized. Operating in an area of no little hazard and encountering unforeseen emergencies at every turn, the aide's capacity to keep his wits about him, to protect himself, and yet to bring service and comfort to the very individuals who at times personally threaten him require a cool fortitude not unlike the bravery so readily extolled in soldiers.

The psychiatric aide is *an individual capable of personal*

devotion. In order that his services have meaning, that they be purposeful, that they be continuous, and that they be consistent, he must be devoted not only to the welfare of his patients and to the staff of professional persons whose therapeutic program he implements, but in addition he must be devoted to the lofty principles of group life in his community, to the administrative body at the helm of the institution for whose protocol he is emissary, and to himself. He must be capable both of self-scrutiny and self-esteem. His dedication to purpose requires an acceptance of many of the best spiritual values that mankind has developed.

The psychiatric aide must possess *an understanding of human emotional needs.* He is more than an employee, more than a participant, more than an observer—he must also be a student of human psychology. In many ways he may be described as something of an "intuitive psychiatrist" and "informal psychotherapist." He must meet needs with appropriate supplies. It is his responsibility to comprehend the language of the emotional requirements of man and not just to respond to their expression through reaction and counter-response. He is a practical psychologist who should be able not only to define the needs of his patients but also to develop insight into his own emotional structure.

The psychiatric aide is *an individual who has the ability to participate as an integral part of a team.* Although autonomy of purpose may from time to time number among his prerogatives in the ward setting, more often he is called upon to extend services and functions already begun by others and then to pass on partially completed responsibilities to yet others. He must be able to gain satisfaction from the oft-repeated experiences of being a mere unit in a continuum of therapeutic forces.

A psychiatric aide in his best realization is *a person who promotes, elevates, and advances human welfare.* He is an instrument of culture, its servant and, where possible, its leader. Accepting the challenge of working with, living with, and feeling with some of the most tormented persons of our time, he assumes a considerable responsibility in creating out of himself an instrument for goodness.

Taken together we thus see that in his best representation the psychiatric aide is a member of the community having

specialized experience, who is an indispensable gear in the machinery of mental health programs, and whose courage and devotion, whose understanding of human emotional needs, and whose ability to participate in team operations render him an individual who promotes, elevates, and advances the cause of human welfare.

That this cause be well served, progress in the development of technical skills and in the improvement of standards of treatment is to be found not only in man's ideals, but, more important, such progress is to be found lived out and exemplified in the daily lives of such men and women as we recognize today.

Today mental illness, the nation's number one health problem, is at last receiving deserved attention. The professional personnel and intensively educated persons in the various services of this field are receiving plaudits, accolades, and interest from the community. In the background, somewhat obscured by the star performers, have been the supporting personnel who are the sum and substance of the time-consuming and arduous activities of total therapeutic programs. These are the psychiatric aides who have too infrequently shared the limelight. These are the silent partners in mental health.

THE MENTAL HEALTH OF THE ARTIST AS AN EDUCATOR IN THE COMMUNITY

MURIEL FOSTER, *Painter*

TO many people the idea of mental health for the artist becomes dispersed in an inevitable assumption that artists are necessarily a neurotic, disorganized bunch whose emotions and drives must remain entirely egocentric and anti-social. Perhaps this does make sense to the non-professionally-creative person. Nevertheless the artist himself has begun to search for the means to understand and orientate himself even in his "neurosis." (This he accepts objectively as a neurosis that he can do something about, according to the data accumulated by the writer in a research project studying 18 professional painter-teachers who were chosen at random. Of these, six had had psychotherapy and all were thoroughly familiar with current psychological and psychoanalytic schools.)

To these vital creative people, mental health for the artist signifies keeping afloat as an integrated personality in a world ordinarily hostile to this particularly productive kind of labor. To the same few, it follows that the artist must first of all consider himself a working member of a community. (We are not discussing here the artist who is more promotional businessman than artist.) And he must take the initiative in this practice even though he may feel unwanted and unappreciated.

Conditions for the artist in this respect, as a component of society, have, of course, varied in previous eras. His rôle until the nineteenth century was as a respected craftsman of plebian, *a priori* value to the projects of community and culture. At the same time, he painted, composed, or wrote what the patron dictated, be the patron church, prince, or merchant. Despite those restrictions, however, he had considerable leeway in techniques and styles of expression so that a certain freedom existed. A madonna might still be the portrait of a favored friend, a king pictured with all the weakness of feature he might have, regardless of extravagant and flattering trappings. A saintly leg could be anatomically distorted and appear all the more spiritual. A poem might extol the vic-

torious conqueror and still become a masterpiece of characterization. A piece of music composed for an effete court celebration might set patterns to be utilized by a century of composers. So the artist could maintain individuality in combination with usefulness in the world about him.

With the nineteenth century, the repercussions of the industrial revolution drove a wedge between the artist and his community. He was needed less and less in a world bent on mechanical development and mass production for peoples who were to become entities to themselves outside the previous paternal guardianship of king and church. The artist then first developed himself totally into an individualistic being. Because this became sterile as an end in itself, he withdrew into his inner self for his ideas of expression.

As the artist turned towards this kind of liberation of his own personality, his own representation of his reactions to the world, he sacrificed his direct contact with the activity of his community or, at the same time, appointment by the people as spokesman of that community. The reaction of the community is understandable in this sense. It could not be expected to probe willingly either above or below the artist's consciousness.

And so the artist's work was accepted only after ground had been broken for reception either superficially on the commercial level of the community, or after a few trained minds had made a clearly assimilated interpretation of it. This procedure required (and still does) the understanding of many complicated psychological processes. For example, it became necessary for any interested observer to overlook the indignity to his ego of not being adequately equipped or capable of comprehending the creative work of his time. This caused a conflict in his reaction to the problem that persists today: an envy of the artist for the freedom of his position, living a little aside from the main current of behavior, coupled with the resentment of the inability of understanding something that society, at least by lip service, considers important. The artist, on the other hand, resented his lack of contact with his fellow men in spiritual and economic ways at the same time that he recognized the development of his rôle as valuable soothsayer and spokesman for his own time even if not *in* his own time. Notwithstanding the political, social, and economic

structure of society (in which art is often given a superficial commercial value), there is much that might be accomplished by the artist to clarify and solidify his position. He realizes more and more that nothing concrete or beneficial can come from complete damnation of the kind of unappreciative world he feels he lives in. He realizes that if his society cannot get along with him, he must get along with it, not by stepping down from his highest aesthetic standards, but by meeting the daily life of his world head-on, with understanding of its effects on his physical and mental being.

He may be accused of anarchic indifference at the same time that he is being diagnosed as the most responsive of personalities. Such a paradox is hard for even him to balance. Perhaps he and his community need to revaluate his need for spiritual and physical independence and withdrawal in their proper perspective as important, but matter-of-fact, components of his work. The arts are a matter of reciprocity between the artist and the public. Every writer wants to be read, every composer to be heard.

Is all this of particular importance to the non-artist, the majority of citizens, who can claim to be more concerned with what is felt to be the serious business of living? It is important for three reasons.

Just because he is so preoccupied with the *business* of living, the average man seldom has the sensitivity or can take the time to probe beneath the surface of life to find its real meanings and directions. This the artist can do for him. Secondly, the average man needs and wants to release his imagination and creative capacity in every metier, because he gets more in personal satisfaction and even material gain by this. (The personality characteristics of the successful business tycoon are similar in many ways to those of the less materialistic artist.) The processes of the artist in the expression of himself, and consequent definition in his work, are a pathfinder for others. At the same time and since, as Hughes Mearns said, "the general approval in our society goes to imitators," society's understanding of the creative person and that person's understanding of himself can help raise the general standard.

Finally, the more the artist comprehends himself, the better able he is to clarify and live with a belief which he of anyone

best expresses: the belief of man in himself, not as a rare, exquisite creature, but as an ordinary constituent of humanity. This should take place without either the crutches of a corrupt temporal and ecclesiastic society as was the milieu of Renaissance humanism, nor the overemphasis of physical science in which this society has placed its hopes and fears.

Mental health for the artist in terms of growth toward personality and career is seldom a conscious thing, except for the few classes for exceptional children in our large cities. The teachers here try to encourage the growth of gifted children, which may be valuable in placing a future writer, painter, or composer on the vague, proper track. But it is only among a rare, limited number of families that a gifted child may be encouraged with perspicacity in the home. Many potential artists, if not geniuses, have, on the surface at least, undistinguished and unprecocious childhoods. Moreover, most children are freely creative in imagination until late childhood.

Improvement here could only rest on a heightened awareness for parents and teachers of the need to continually encourage the childish free play of expression, with more stress placed on sensitivity from the child's point of view, *i.e.*, sensitivity arising from a conflict between his very introverted, self-centered reaction to events and feelings, and the matter-of-fact, critical observance of his behavior by his peers.

It is the writer's opinion, however, that the foregoing familiar and generally conclusive summation of the creative climate of the child might be enlarged. In our culture, which already has a Freudian heritage, we have learned that the development of a child before puberty is often a question of the curtailment of his natural egoistic desires for the necessity of adjusting to the life he will live with others, whose own wants he will have to consider. But we also have a tendency to urge a certain general standard of conformity on all children, regardless of their own adjustments to the world or their personal needs. We are guilty of this at all age levels, but with less knowledge perhaps of the results with children, and especially gifted children. We overlook the fact that the gifted child is somewhat aware of his potentialities. This intuition may be vague, but the ambition to write, paint, or compose may be formulated by eight or nine. This kind of child already feels a little different from other children his

age. He may not have a mental picture of this, but he does feel it. (Nine artists in the writer's research said they were conscious of this as children, before adolescence—one as early as five years—in a manner ranging from actual decision to pursue an artistic career to indistinct but willful feelings of a special insight for that purpose.) It should be possible for families and teachers to lend a non-condescending affirmation to these yearnings in terms of a special future preparation, avoiding the strangulation-of-the-virtuoso technique that is the other extreme.

This can be done only if the neophyte is handled in a matter-of-fact way and unselfconsciously and concretely helped to summon more drive to carry his interest through puberty and early adolescence with its shocks of crude reality that can completely choke off the free creative expressiveness of the child. The problem is, of course, one of keeping the spontaneity of the child and, in addition, the discipline of order. Too often, because of adult suspicion of the creative personality, this is an attempt at moderation. And moderation can become a washed-out compromise foretelling a personality that can participate only at half strength, with great anxiety.

Perhaps balance is needed here, balance as a middle between two extremes—those obvious extremes of either giving the child his head in all-out self-determination, or complete restraint and lack of confidence in his course of action in choice of careers and techniques. Either of these extremes has always been explosive, as the denial of one forces a dynamic against the only other outlet, which leads to the inbalance and distortion of personality of which many artists have been victims. It has never been proved that the sensitivity and insight of creative people are not primary forces of creativity rather than the traditional neurotic conflicts (which are more often useful to an artist in pushing him through all the barriers that surround his kind of career). But we place little value on sensitivity and insight, particularly in children beyond the kindergarten age. Then they must get "tough" enough to meet competition. (The artists interviewed in the writer's research project considered themselves tougher in their sensitivity than other people, because they were able to conduct their activity in the world outside themselves with more objectivity—to see behavior and mores so clearly that

they could choose outside behavior of their own at will with much humor and often some contempt for rigid modes of manner.)

One of the main problems to be treated in helping the adolescent artist is his conscious unwillingness to expose to anyone else his real feelings, which most certainly will appear in any serious creative work, and at this period with powerful intensity. This combined with his need to learn techniques, to say what he wants in terms of the real world, can often reduce his work to imitative levels. To the knowledge of this writer, this question has never been handled by discussing the subject matter of his art (as a whole) directly with the student, reassuring him about the validity of his emotional reaction to the world, rather than just the validity of free expression *per se*. This would, of course, require an uncommon amount of tact and rapport and confidence.

Paralleling this, an understanding of the artist's position in regard to the conventional rules of life might be interpolated. Sheer rebellion against conformity is not the intelligent procedure. (It is the writer's experience that there are three kinds of students in an art class for children and adolescents: those who want to please the teacher every step of the way and who may become artists by dint of application for this approval; those who completely rebel against all suggestion and method, who will become artists if they do not get too far out of adjustment; and those who are too immediately concerned with the manner of behavior of the average child of the group. They will not be able to become artists.)

The rules must be understood and used individually, constructively. The student has to understand that reality is different for everyone; so it is quite right for everyone to interpret the rules differently. His rules also must be organized so that he can eventually achieve some control over the problems of living that he has to face (to accept the economic necessity of a job, at least at the beginning, and to control his energy for his own work, for example). He needs to start understanding the importance of discipline. Discipline is not used here in its definition as the basic professional school function of training the student to get to his easel or typewriter to work by sheer repetitive habit, but rather as meaning work by choice and free will.

The adult artist, for the purposes of this article, is the artist who has developed his work to the point of painting or writing independently, with some foundation of his own style as evidence of his own personality in his expressive form. His biggest problem is one of energy, whether or not he has to work at some money-raising job such as copywriting, teaching, selling, etc.

This man or woman needs to muster his forces consciously to devise a form of routine for working: to highly organize his life so that his own work can assume control at its proper time, enabling him to relax in it and follow its moods and intuitive directions. This sounds quite simple and obvious, but many artists waste years of trial and error in determining the best time of day, the best discipline, the best physical environment, most fruitful, stimulating recreations, simply because at the onset of mature work no analysis of these problems was undertaken or even given a meaningful significance.

Most of all, again, the artist must clarify his values for himself. He may want all kinds of experience, but he must find a means of selectivity for himself. He must understand that his values, rightfully, are a little different from those around him and keep his choice alive. He has to realize that emotional growth is valuable. When it is said that "there is a child in every artist," he must know that this refers to freshness of vision and spontaneity of expression, not arrested emotional development and childishness. He can learn, again, that reality is good for him, his ego functioning as a meeting force between his objective and subjective attitudes. It is only this merging of the two that will give his work through his personality any validity.

How can he become aware of this? Proper guidance in his art schools and colleges should be as available to him as to engineers or business executives, who may, at first glance, be associated with more prosaic professions in terms of concreteness of theory and practice. In amplification of proper guidance, here it may be suggested that the artist-student might consult with a guidance counselor in reference to the type of work he intends to do. If it is to be fine arts, writing or composing, the best way he may use in supporting himself in a secondary job (part-time, perhaps) might be pointed out, and various ways of alternating his schedule for the most con-

centrated work. But more importantly, the student might through the help of another trained person gain more insight into his own special problems of style, technique, and the creative process in relation to his own personality, and with this more indication of rapport with his chosen group.

How would this be fruitful to the community? It would serve to reflect the capabilities of the artist more directly for benefit to the community and help raise its cultural values. Where the artist is better equipped to meet and understand his society and his place in it, he can the more intensely reach it as a valid member of it. (This is not meant to imply a vulgarization of what the artist has to say—this he must always do on his own terms or he does not create art.) He certainly needs to interact with his society in a more positive fashion than by willing it an inheritance of his work.

One of the elements of his creative personality is the lack of division between his work and what he is. The artist wears a mask more thin than others, because he is himself. He has chosen what he does as a labor of love. There is no schizophrenia between himself and his job if he has matured professionally. This goes beyond the mere joy of doing the work and includes a psychology that can be useful to people concerned with other occupations or more humdrum tasks. The artist tries to do his job well to satisfy himself according to his *own* standards. This is not to say that he cannot apply a material value to his work, on the other hand. So the average person who is selling his services for money in a job need not always feel that he should keep his personal interest in functioning well out of it. (The artist applies himself just as thoroughly on work other than his own, because he sets his own standards of quality, and also because he is interested in learning more about living in any milieu.)

The artist draws an analogy between what he thinks and what he does. Perhaps this may be educatively possible for others. This may go against the main current of conformism; however, a little more conformism in our society may wipe out the vitality that individualism of our kind has created. The artist is sensitive to his surroundings and consequently usually tries to make them more pleasant, at the same time making his work more pleasant, an attitude that is daily becoming more respectable in the business world.

The artist lives intensely but does not develop high blood pressure more often than anyone else. He can say that he has experienced life even if he lives for twenty years in a four-block city area or an isolated village. Therefore he always feels alive, even to drudgery. And because what he does he does of himself constructively, he is not continually either burying or wasting his psychic energy. Many amateurs in the arts have begun to realize this: that approaching work creatively is a constructive release for emotions.

In every creative work there is a step-by-step development of material from the first insight of an idea, conceived in imagination, through the final touches of it. It may be true that the flash of illumination that darts in to start a painter on a picture or a composer on a symphony can only arrive after the artist has completely digested and understood his material, knowing it well. Memory has been thought to be the settling, mellowing factor from which the artist must produce. The writer, however, believes that time has very little to do with this. Rather, it is understanding, knowing thoroughly, that equips the mind with the means to say anything about an imagined idea. Because emotion is added to memory, so does the idea express itself differently in any person. (The investigation with artist-teachers revealed that nine of the subjects thought that emotional experiences affected their work immediately, whereas seven others, all out of a total of eighteen, thought that this occurred part of the time.)

Another phase of creative activity is the urge to work which an artist may get because of an emotional disequilibrium. He feels unfulfilled so he sits down to express himself, letting out his discomfort. Other people repress this or see a movie or TV show instead, but with, perhaps, the same emptiness continuing afterwards.

The artist identifies himself with life and nature. He reads himself into other people and life situations. This human capability is forgotten by those who do not find an outlet for their energies. An empathic individual is not an enemy to society, but do we teach this as a method? We say, consider your neighbor as yourself or live and let live, which are platitudes on a highly ideal level. Cannot we show young people the empathic process going on between all persons

without glossing over a very normal projection with allusions to morality? Understanding this objectively and its application might help prevent such quantitative manifestation of the strictly self-seeking person. In the teaching situation, and particularly in painting or writing, the empathic rapport *must* exist, for so much of what must be learned depends on the personalities in the class. In this connection several interesting answers were obtained in research. Of the artist-teachers interviewed 75 per cent thought that their students "felt themselves into" or were aware of their teacher's problems. Of the same group, 87 per cent believed that those students who were most sensitive to the wants and needs of others also had a better grasp of form in their painting.

The artist can also be a useful teacher in spotting outgrown habits of thinking that keep an individual from expanding and developing. In the same manner, the artist fights a society that tries to separate thinking and feeling. Often this fight is bungled, and so we see the full-blown bohemian who has some of the rebellion but none of the depth for real creative work. A respect for people who fight for more understanding and beauty for life can only be taught today, just as independence of spirit will have to be learned again by those who envy it in the artist but who are too ridden by fear to believe it in themselves. Yet without it many of them are breaking down. And this same independence of spirit is part of the emotional independence contained in the emotional maturity that everyone would like to reach.

Change is difficult for most people to comprehend just as it will be perhaps increasingly difficult for those who were born before the 1920's to realize all the implications of the atomic age in the coming generation. There has also been a change in the artist that has really been his first attempt to adjust to the upheaval of events as remote in time as the industrial revolution. The artist has stopped screaming about his uselessness, and has started to demand his rightful place. He asks that the rest of the people move enough to give him standing-room—not as they would break away for a cripple, in uncomprehending pity, but as they would casually make way for a man carrying a large bundle.

The artist is learning how he can work as a complete entity instead of believing in a myth of omnipotent discontent. He

fights for the right of intuitiveness, however, even though he feels that he can know people more thoroughly with an understanding of such scientific aids as psychology and coordinated teaching methods. He recognizes that his expression of imagination is essentially a communicative one, unlike the fantasy of day-dreaming, for example. He and his fellow men can begin to see by means of education that creative thinking can be habitual, because emotions can be trained to react according to the habitual plan of the mind, the eyes, and the ears, if people are made aware of the simple, forgotten fact that this might be done intentionally as specific subject of learning, as well as further exploration psychologically.

Reams have been written on both the creative process and the importance of the artist on the historic-social scale. Can we not apply some of this knowledge directly for use in the society? We have already done this to a certain extent for our scientists. Why not for the painter, writer, sculptor, or composer?

THE CHILD IN THE HOSPITAL *

In 1951 the WHO Regional Office for Europe as a part of its long-term activities in child health initiated plans for a meeting between pediatricians and child psychiatrists at which they could discuss their respective rôles and the coördination of their work.

Early in 1953 an ad hoc *committee was called together to discuss the possibility of holding a conference which would delineate the rôle of the pediatrician in the management of psychosomatic and behavior disorders in young children. This committee, consisting of leading specialists in pediatrics and child psychiatry, under the chairmanship of Professor R. Debré (France), felt that any wider conference should be devoted to considering more fully the interrelation of somatic and psychological processes in sick children, the respective rôles of pediatricians and child psychiatrists in their treatment, and the working relations between the different disciplines responsible for the care of children.*

In order to avoid diffusion of effort, and to arrive as far as possible at practical conclusions, the study group that was subsequently convened in Stockholm concentrated on one important aspect of child care — the child in the hospital.

* Account of the meeting of a study group, sponsored by the Regional Office for Europe of the World Health Organization in coöperation with the Royal Medical Board of the Government of Sweden and the Department of Pediatrics, Karolinska Hospital, Stockholm, held at Stockholm on September 2–11, 1954.

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Copies of a French translation of this account may be obtained on request to the WHO Regional Office for Europe, Palais des Nations, Geneva, Switzerland.

There is a list of participants at the end of this article.

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Introduction

THERE is a growing realization of the need to consider the child as an entity and to bring into play all the resources for the protection of his mental as well as his physical health. Yet the degree of coördination and team work between pediatricians, child psychiatrists, and other specialized workers concerned in this field still varies tremendously. In some countries psychiatric services have scarcely developed, while in others the available child psychiatrists play a limited rôle, if any, in the pediatric services.

The primary purpose of the meeting in Stockholm was to bring together in Europe representatives of the principal disciplines responsible for the care of children in the hospital. In the course of their study and through the exchange of their very considerable experience the specialists in the study group arrived at certain broad conclusions which may serve to stimulate further interest in child care.

There was no fixed agenda, nor were there predetermined plans for conducting the discussion, except that it should keep within its agreed scope of the child in the hospital. Six case-histories were presented by pediatricians and child psychiatrists who normally work together, in Sweden, the United Kingdom, and the USA. These case-histories were chosen to illustrate the comprehensive care of the child in the hospital and problems of staff coöperation, and not for the purpose of discussing their clinical aspects. After the presentation of each case, discussion followed under the leadership of a chairman selected in rotation.

The study group included 20 pediatricians, 10 psychiatrists, a medical social worker, and a psychologist, from countries representing a wide variety of conditions. A Swedish nurse was also present during the discussion of one of the Swedish case-histories.

The entirely informal character of the meeting led to frank and spontaneous discussion with keen interest in understanding different points of view.

Although the group concentrated on the work carried out within the selected environment of the children's hospital, there was frequent allusion to the need for similar studies on relationships with the family doctor, the obstetrician, and the

personnel of child welfare centers. Among other related problems it was felt that hospital design required further study.

Much attention was focused on the urgent need for a new approach to training and for important changes in the curricula for physicians and nurses working with children. The extent of factual knowledge in many medical fields is one that the most highly gifted individual can barely encompass. Specialism is inevitable, but the continuous process of fragmentation of knowledge cannot continue without detriment to the individual and society unless there is a compensating synthesis in basic training and in practical team-work. This was emphasized time and again in the discussions.

There are certain fundamental aspects of knowledge about family life and child development and the effect of illness on the individual which are still almost entirely neglected.

Future emphasis must lie in learning and relearning the basic essentials, and in the fullest use of available specialists, not all necessarily medically trained but able to provide the additional information in their own field on which a successful synthesis in diagnosis and treatment may depend. It is not fragmented knowledge but a whole approach to the child in his present environment that is needed. And it is the children's physician and the family doctor who are best placed to discern what special skills are required, to coördinate their use, and to effect the synthesis.

This account can only inadequately reflect the general feeling and atmosphere of the meetings of the study group. The detailed discussions that occupied seven working days are necessarily given in summarized form, but their range and main trends are indicated, including suggestions as they arose, sometimes from individuals, sometimes from the group as a whole.

Three major topics emerged in the course of the discussions. The first concerns the total well-being of the child in the hospital in terms of his emotional and physical needs. This leads to the second consideration, the basic training required for work in this special field. The third topic is the coördination of services within the hospital.

Some general conclusions and many suggestions are described under each of the three main subjects in the hope that these may stimulate increasing interest and further study.

Children in the Hospital

Few will dispute that the best place to care for a child is in his own home among familiar surroundings, where the people who normally give him security and affection can tend to his needs. The young child under five, in particular, is unable to understand what illness is. Even for an adult, who knows that the interlude will sooner or later come to an end, admission to a hospital is a major event. For the small child, who has no realization of time, the break is final and irrevocable unless he has some tangible means of grasping that this is not so.

Moreover, increasing knowledge of the child's emotional development has brought home to us once more that physical care does not necessarily go hand in hand with mental well-being. Experience clearly illustrates that admission to a hospital, particularly where the atmosphere is "institutional" and frigid, may lead to acute depression that can reduce the value of physical care and even contribute to a fatal outcome. It may also impair the child's mental outlook for the rest of his life.

It is necessary, however, to be realistic about the question of admission to a hospital. Two major issues have to be faced: on the one hand, the child's physical state must have the best consideration and treatment that medicine can give; on the other, his emotional needs are just as important and must be equally well cared for.

The study group not only considered criteria for admission and how best to minister to the child while under hospital care; it also realized that if he is indeed to be cared for as a human being, with thoughts and feelings as well as physical needs, he must be prepared to meet the change and stress consequent upon admission and later upon discharge and after-care.

The Problem of Admission

It sometimes happens that after frequent attendance as an out-patient a child makes little progress and is admitted to hospital because the pediatrician is at a loss what to do next. No pediatrician is practicing good medicine if he admits a child to a hospital for this reason alone. The physician must

be clear as to the reasons for recommending admission and what investigations he proposes to undertake. He may want to see his patient in the environment of a hospital, using the knowledge thus gained to advise the parents. Yet whatever the motives, whether they are primarily observational or primarily therapeutic, he should first be convinced of the unconditional necessity for this step.

Apart from cases where admission for investigation and treatment is essential or a matter of emergency, there are also other considerations arising from social conditions.

Many illnesses could be treated at home if the services and available care were more adequate. Two very real problems are raised in many cities by overcrowding in the home and by the fact that both father and mother are often out at work all day. Under such circumstances when a child falls ill the immediate reaction of the parents is to seek his admission to a hospital, where he is likely to be adequately cared for. There is no doubt that pediatricians are often forced to accept this situation and admit children when they would otherwise choose to avoid a separation from the home.

Such problems can only be met by social measures which, strictly speaking, fall outside the special province of this study. Nevertheless, as the factors mentioned often closely affect professional decisions on admission to a hospital, a valid social argument can be advanced for improving medical services and care within the home.

With this in mind it was suggested that:

(*a*) a reserve staff might be established for enterprises employing women so that mothers could be released to care for their children when they fell sick, without losing their jobs;

(*b*) a mother should be given a daily benefit equivalent or comparable to her wages to enable her to look after her child in such circumstances.

A Hospital Case from Background to After-Care

In order to illustrate a number of the problems raised by the admission of a child to a hospital some brief extracts are given from the case of Johnny, which was presented to the study group as a basis for discussion.

History and preparation for admission

Johnny, aged 2½, had suffered for 18 months from repeated upper respiratory infection with severe head colds and ear-ache. His speech was very unclear, his behavior restless, destructive, and demanding; he was suffering from broken sleep and frequently came into his parent's room at night.

He was the only child of a 23-year-old mother and a 27-year-old father, who was employed as a clerk. The mother went back to work as a full-time telephone operator when Johnny was six months old. Her schedule was irregular and Johnny's home life in the over-indulgent but quarrelsome atmosphere of his grandparents' flat had been chaotic. When he was two, however, his mother gave up her job and the family obtained a flat of their own.

Despite his background, he was a contented child until he went to the hospital at 20 months of age to have a lipoma removed from his right arm. He was an in-patient for three days and visiting by the parents was not allowed. When he returned home he was found to be tense and irritable and unable to settle to any activity for more than a moment or two.

When, in the present instance, he attended the hospital, the clinical examination was difficult because of his irritability and restlessness, but he was found to be physically normal except for his unhealthy tonsils and adenoids. He was given symptomatic therapy and seen again three days later.

After careful consideration, tonsillectomy and adenoidectomy were advised and his mother was asked if she would come into the hospital and be with him all the time. This she agreed to do, though with some apprehension. A week before admission he attended the hospital again, this time in order to be told in his own language what was going to be done to him, and to be shown where he would stay.

It was explained to his mother how she should talk to him about the operation on the two days prior to his admission, and she discussed with the medical social worker certain anxieties she herself retained in connection with operations she had undergone. The boy played with a nurse during this interview.

As this child had fears about defecation and was as yet not toilet-trained, the nursing staff were asked to avoid all manipulations round the anus such as would be involved in rectal temperatures, enemas, or anesthesia. They were also asked to help the mother to take an active rôle when she was in the ward and to encourage her to speak freely about her own anxieties and to ask questions.

Admission

Johnny settled down to play happily in the playroom with the other children and slept well the first night. The following day the nurse, whom he knew, gave him his preoperative injection and took him to the operating theatre, as he had been told would happen. Unfortunately, he was still awake when he reached the theatre and he struggled for a few moments while going under the anesthetic.

His mother was present as he came round from the operation, which was uneventful, and was able to reassure him as he awoke from time to time. The following morning it was with reluctance that he left the playroom in order to return home.

After discharge

Three days later he attended the hospital for the routine throat examination and was encouraged to play with the toys and water. He showed no fear on returning and seemed to have suffered no ill effects.

A developmental examination, given in due course, showed that he had made more than 12 months' progress since his first examination nine months before, and a nursery school was recommended. He had in the meantime become very coöperative about his toilet training. A key factor in improving the mother's relationship with the child had been the hospital experience, during which she had learned to handle him more consistently and understandingly. As his health improved she grew proud of his progress and was able to show him increasing affection and approval.

Planning for Admission

Johnny illustrates a not uncommon history of traumatic experiences due to unhappy separations from home or earlier hospitalization to which the child has reacted badly; it is most important that the full background in such cases be brought to light.

In other cases, though less time and effort may be involved, admissions should always be carefully planned by the pediatric service in the light of knowledge of the home background and of what the hospitalization is attempting to achieve. So far as possible, account should also be taken of the child's age and understanding.

Unfortunately, our knowledge of what the young child understands and perceives at each age level in terms of the body image is not yet complete. What we do know is that without some explanation and adequate precautions he easily resorts to troubled fantasies. This particularly applies to children in the pre-school and infancy periods. They frequently feel what is happening to them to be a rejection on the part of their parents or a punishment for some way in which they have behaved, and unspoken fears may remain with them for the rest of life.

Careful precautions should be taken in the timing of the admission. For example, the pediatrician should, where possible, avoid sending a child into a hospital just before or after the birth of another baby in the family, especially if the child in question is too young to understand why he is going there.

There are also ways of helping children in a general manner. In one country, a booklet is in use giving advice to parents on

the way to prepare their children for admission, and this has proved of value. This idea might be further developed by inviting an artist skilled in illustrating children's books to produce a suitable publication after making himself familiar with the hospital atmosphere.

Emergency cases present a different problem. Various circumstances may necessitate sudden admission, at times matters of life and death, where the physical aspects have to be dealt with first and foremost. The situation is usually one of anxiety. The parents need help and support, and should be allowed to stay near the child and be with him when he regains consciousness. Should they be over-excited and have a disturbing effect on the patient they may be allowed to stay on the premises but should not have intimate contact with the child. In such cases, the medical social worker can play a valuable rôle.

The psychological problems that arise in instances of this kind are best resolved by letting the child subsequently "play out" his experiences in the hospital playroom, where he is under observation and has the help of the play nurses. This "abreactive" activity should be encouraged when he is in his own home again.

Admission of the Mother with the Child

In spite of the fact that the mother herself had some anxieties about being in a hospital, it was decided in the case of Johnny that it would be traumatic to him if he were left alone without her after his earlier experience. There is no doubt that her admission proved valuable in allaying anxieties in the patient and in educating her as a mother.

When should arrangements be made for the mother to come into the hospital with her child and when is it inadvisable? There are often other young members of the family who need the mother's care. The father should not be forgotten either, and in the interests of good family relations, if his wife is to accompany the child, he must have a proper understanding of the need for this step.

If these difficulties can be satisfactorily overcome, should the mother be admitted with the young child in all cases?

In this connection attention was drawn to the outstandingly good results which had been obtained by the Pickerills in New

Zealand[1] in a hospital for the surgical treatment of infants where every child is accompanied by his own mother, and lives and is cared for entirely by her except when he is in the operating theatre.

On the other hand, it may be asked if there is not a tendency, in avoiding all trauma, to make the child's life too easy. There will be general agreement that life cannot be lived without experiencing difficulties and the struggle to overcome them. But with small children the "dosage" of stress must be graded, as the level of tolerance is low. Certainly, children must meet tension-producing experiences, but they need to be helped to develop a gradual sensitivity to some situations and the necessary insensitivity to others at the optimum pace. Some parents are in the habit of "toughening" their children from birth because, they say, "life is tough and real." There are pediatricians, too, who "streamline" infant feeding to the point of giving infants three meals a day at the age of six weeks whether they need it or want it. When children are upset by hospitalization it is not uncommon to hear it said: "As long as there are child psychiatrists and child guidance clinics to take care of the casualties, let's not worry about the rest."

The need for prevention in the psychiatric field may not only tend in this way to be minimized as a matter of policy; it may be neglected under the sheer pressure of clinical activities.

In the light of these considerations the study group wished to emphasize the value of the mother's admission as a prophylactic measure. It has been a frequent practice for many years with private patients, and has undoubtedly proved its value. When the pediatrician and psychiatrist feel it is of major importance, children should have their mothers with them throughout their stay in hospital. In certain other cases, the mothers should at least spend the early period of the admission with the children to help them to settle in.

Technique of Reception

In all cases, whether the parent stays in the hospital or not, the "technique of reception," which calls for an imaginative

[1] Pickerill, C. & Pickerill, H. P. (1954) The elimination of hospital cross-infection in children: nursing by the mother. *Lancet* 1, 425; *Lancet* 1954, 1, 447 (Editorial: The mother as nurse). Further reference is made to the work of the Pickerills later in this account.

appreciation of the child's feelings, should be made a subject of careful study.

At this stage it can be said that he should not be deprived of the toy from home with its familiar smell or be divested of his own clothes, nor should a bath be forced on an unwilling and anxious child. The ward he enters should be a small one, with furnishings he will appreciate, and his bed or cot should be in keeping with what he is used to at home. These small and apparently trivial details are important ones for any child.

The staff, in helping him over the separation from his parents, should avoid obvious deceptions, for above all the child needs to feel confidence in those who are going to care for him.

Hospital Design

These considerations raise a further important problem — that of hospital design. Hospitals in the past have generally not been constructed in such a way as to promote the homey atmosphere that is desirable, though in many cases much can be and has been done to modify internal arrangements. Modern hospital planning and construction, on the other hand, at times shows a tendency to other faults. In particular, there is the hospital of ultra-modern design, with the last word in technical equipment, where, in contrast to the large old-fashioned general ward, each child is in a separate glass-walled compartment conveying the impression of a refrigerator.

There is a strong case for more extensive examination by doctors and architects of the problem of hospital design for the future; consideration should be given to the provision in children's departments of small wards or rooms capable of reproducing home conditions and with accommodation for accompanying mothers. In a number of cases a satisfactory arrangement has been provided by separate cottages or "pavilions."

Hospital Procedures

In the case of Johnny, care was taken to avoid any routine procedure that might be harmful to the patient. From the discussion it was clear that routine procedures, though often not essential, continue in many in-patient and out-patient departments. The highly-skilled and sensitive physician is

alive to the need to dispense with many routine activities, requests for unnecessary investigations, the use of old-fashioned and clumsy apparatus such as heavy syringes, and pre-operative enemas. These and many more procedures should be given careful consideration in the light of what they mean to the child. In this connection, too, the child should not reach the anesthetic room in a state of frightened awareness.

Even more important is the creation of the right emotional atmosphere in the ward. Here, two main contributing factors received especial attention: day-to-day care of the infant or child in terms of his relationship with the staff, and the maintenance of home contacts.

Relationship Between Child, Nurse, and Doctor

Divorced from his home surroundings the child needs to acquire some familiar support which will give him a sense of security. This is often denied him when he is faced with a succession of different nurses at his bedside.

One instance was given of a West African nurse, whose success in a children's hospital was attributable in part to the ease with which babies could identify her in a sea of other faces. Normally, the familiar face, the intimate touch and especially the sense of security, can only be provided when each child is assigned to one particular nurse to whom he becomes accustomed throughout his illness. Despite the shortage of nurses every effort should be made to insure that this is done. This also applies to the doctor. Having once started to form a contact with the child in the out-patient department he should, whenever possible, follow through the treatment to the final stages.

Visiting and Family Contacts

The Visiting Mother in a Case of Feeding Difficulty.—The following case is presented very briefly to indicate how a mother's visiting was planned to fit in with the therapy.

> Sammy was a 13-months-old boy living in a socially and economically deprived home, who was admitted to the hospital because he had refused solid foods from the age of 6½ months. This fear of solid food had produced a severe iron-deficiency anemia, a retardation of development, and increasing weakness. Despite efforts on the part of a social welfare agency to help the mother, no change for the better took place.

The food refusal was diagnosed as the manifestation of a disturbance in the mother-child relationship. Hospitalization was advised in order to provide a favorable environment in which the mother might establish a good relationship with her child, and to investigate and treat his anemia.

The nursing staff were given full information about the child and were specifically asked to let the mother feed him when she visited him twice daily. He was given a blood transfusion and iron therapy, and his response to the attention and help began to show clearly by the third day when, for the first time, he began to eat solids and to play with toys in his cot. He welcomed his mother with obvious pleasure and was unhappy when she left, but he subsequently became happy and smiling with the members of the staff who cared for him.

From the ninth day he sat up easily and ate everything that was offered him. On the fifteenth day he went home to his mother. His progress was then followed by the medical social worker and the public health nurse who maintained contact with him and helped the mother to get toys, a playpen, and a high chair, also advising her over various points she raised. He was seen regularly at the well-baby clinic and proceeded to make rapid strides in his development.

The salient point in this case is that while physical treatment in the hospital would probably have afforded Sammy symptomatic relief in any case, it was only through the mother's education and change in attitude within the hospital environment that the vicious circle in her relationship with the boy was broken. Thus, he could be sent home without fear of a recrudescence of the conditions that gave rise to his complaint.

Some Different Approaches to Visiting.—In this case the full significance of visiting is abundantly clear. But in other cases, where the relation between it and therapy is not so evident, visiting still plays a most important rôle.

It is interesting to note that in Italy, a country traditionally warm-hearted in its attitude to children, visiting has never been forbidden except in individual cases where it has been considered to be to the serious detriment of the child.

An interesting contrast to the particular western trend of "toughening" the young child was cited from the customs of another culture. While working in East Africa, one of the study group had noted that when a child was admitted to the hospital he was never alone during his whole stay there. His mother or some member of his family was always by his bedside day and night, sometimes, indeed, the whole family. One of the difficulties was to prevent the mother from removing the child from bed during the night to sleep with her on the

floor or, if she was told this was not the best thing to do, she would then want to get into bed with the child. This had given him food for thought, for there appeared to be less evidence among these children of psychological disturbance. He later worked in close contact with Dr. J. Bowlby, on the steering committee at the Tavistock Clinic, which was engaged in studying problems arising from the separation of mother and child in early life. He had come to the conclusion that he must change the existing rules in his ward and with the collaboration of the head nurse it was decided to permit daily visiting in selected cases. The results proved so successful that head nurses in other wards asked for it as well.

There is a tendency, probably due to the exaggerated attitude of the lay press, for mothers of young children who have undergone hospitalization to blame all behavior difficulties on this experience. Parents, however, often have a right to complain that family contact with the child is not given its due consideration. The first hospitalization in the case of Johnny illustrates the possible ill-effects of denying visits. There are still children's hospitals in a number of countries where visiting is forbidden and many others where it is grudgingly permitted once weekly, or even less, while little understanding is shown of all the emotional implications which are involved.

Visiting and Infection.—One of the arguments against visiting has in the past been the risk of infection brought in from outside. When wards were big there were few facilities for isolation, and deep concern was felt when a child admitted for one complaint contracted another illness and died in the hospital, an occurrence which was all too frequent 30 years ago. Since then a new situation has developed.

Thus, in the United Kingdom, when the rebuilding of hospitals was under consideration in 1945, the British Pediatric Association set up a small committee which studied factors that might affect their design.[2] Among these, the question of cross-infection was investigated and it was noted, from a careful statistical analysis of material collected in 12 different centers, that there was no positive evidence that visiting by adults in any way increased infection.

[2] Watkins, A. G. & Lewis Faning, E. (1949) Incidence of cross-infection in children's wards. *Brit. Med. J.* 2, 616.

The indications are that hospital infection is usually introduced by other children and the experience, already mentioned, of the Pickerills in New Zealand, where mothers are admitted with their children, supports this view. Moreover, pediatricians now have new drugs at their disposal for the control of infections. This makes it easier to turn to a fuller consideration of the child's emotional and mental requirements.

Technique of Visiting.—In order to introduce visiting effectively various factors need consideration. In large hospitals visiting hours have to be staggered to prevent congestion. In New Haven, Conn., for example, they are flexible — the mother and father being permitted to visit children not critically ill twice a day between stated times, while in critical cases arrangements are even more relaxed. There is no compulsion on mothers to visit, but they are encouraged to do so. In a number of hospitals experience has shown that both visiting hours and the regularity of visiting must be selective, bearing in mind the child's relationship with his family and the parental attitude.

The over-anxious, disturbing parent and the child with a very distressing illness often present visiting problems, and in some cases it may be advisable to apply restrictions. Nevertheless, a mother may insist that she has a right to see her child. The pediatrician should resist this attitude, for the child is under his care and it is he who must make the final decision in the interests of the well-being of his patient.

The handling of visitors is a question that deserves careful attention and if properly organized can bring valuable results. Mothers are found to fit into the life of the ward much more easily when given something to do; it is inadvisable for them to sit aimlessly at the child's bedside. They should be encouraged to play with the child, to give him his evening wash and his supper, to read a story, say his prayers with him, and tuck him up for the night. With luck the child will fall asleep before his mother has slipped away.

While for the younger, more vulnerable, ages contact with the mother is irreplaceable, older children often value visits from their friends of the same age, and such visits have been encouraged with good results.

The visitor who at times fits less easily into the hospital

surroundings is perhaps the father. This does not mean, however, that his visits can be neglected.

Finally, the fact must be faced that visits, however well organized, inevitably cause a temporary disturbance, not only in the hospital routine, but to the patient. It is often felt by the nursing staff that the brunt of this disturbance falls upon them, both during the visits and after, when the child most keenly misses his visitor. Many parents, too, have questions to ask which the nurse does not always feel she can answer. For these reasons parents should have easy access to the head of the department and a doctor should always be present whenever possible to give support during and for a short while after visiting hours.

Visiting in Long-Stay Cases.—The psychological difficulties which inevitably arise when children with chronic illnesses have to stay in a hospital for many months raise special visiting problems. To maintain a steady relationship with the family is difficult enough when the hospital is within easy reach of home; but when it is situated a long way off in specially chosen healthy surroundings its comparative inaccessibility makes the task well-nigh impossible. There is good reason to subject the value of long-stay special hospitals and convalescent homes to very careful review. There can be no doubt that the case of each child about to be sent away for long-term treatment should be thoroughly examined from every angle.

It is of interest that before admission to one school for children with cerebral palsy each family is visited by a psychiatric social worker, and full psychiatric examination is made of the child some time ahead. The best method of maintaining family relationships can thus be fully explored.

Many members of the study group felt that for visiting remote long-stay cases parents should not only be allowed travel allowances, but should be paid for their loss of time from work in order that the family contact might be maintained.

Where a special hospital is situated near a big city most of the children can be visited, but there may be one or two children in a ward whose parents live too far away to pay more than rare visits. The pediatrician must bear in mind that such children may become psychological casualties. Every attempt should be made to prevent this; where there are play nurses

these are invaluable, as they can devote extra attention to the lonely child. The good offices of local visitors can also, in part, alleviate the problem, though neither can fulfill the rôle played by the parents.

Preparing for Discharge

In the well-run pediatric hospital, with an understanding staff and good playrooms for the ambulant child, it may be found that the young patient is reluctant to go home. In general, this would not support an argument for more frequent and longer admissions, though it may, in individual cases, indicate that a child's home life lacks the facilities for friendship and play and the sense of security that he has unconsciously come to appreciate in the hospital.

The unfortunate effects of the less adequately run pediatric hospital have already been indicated, and in any case hospitalization may subjectively come to represent rejection by the parents.

Under these circumstances what methods should be employed to render the discharge smooth and uneventful?

The pediatrician will, of course, give his advice to the parents in the light of what he has learned of the home conditions from the family doctor or the social worker.

There is a growing practice now for pediatricians to see the parents not only individually, but in groups. It has been found of great value to invite the parents of children suffering from one disease, as, for example, diabetes, to come to the hospital together and discuss their anxieties freely with the pediatrician. The latter, in turn, explains to them frankly how they can best help their child after discharge.

If the child has been in the hospital for a long time, and his home is at a distance, it is helpful if the mother can spend a few days with him in or near the hospital prior to discharge. Another alternative is for him to go home, first for a day and then for week-ends, before his final return. This, especially in the case of an older child, makes for a smoother transition.

In these matters the medical social worker and the public health nurse have a very important part to play. They know the home situation and can help in the smooth reëstablishment of good relations. If the child remains in an over-anxious state and is in dread of the hospital, it is these workers who

are best placed to discover and bring it to the attention of the pediatrician.

It need scarcely be emphasized that continued contact between the child and his parents throughout his stay in the hospital offers the best assurance of a smooth transition on discharge.

Conclusion

The main points that emerged in the course of discussion may be summarized as follows:

1. A child should be admitted to a hospital only when the pediatrician is fully convinced of the necessity for his step; the fact that admissions are sometimes made because the right conditions or care are lacking in the home points to the need for social measures to meet the situation.
2. Admissions, wherever possible, should be planned ahead and timed in the light of the child's age, his family circumstances and background, and in relation to the purpose to be achieved; in emergency cases, where this cannot be done, it is suggested that adequate provisions for play therapy within the hospital may considerably ease the effects of sudden admission. Published advice to parents on preparing children for admission can be helpful and meet a real need.
3. Provision should be made for the mother to be admitted and stay with her child where the pediatrician considers it necessary, and in other cases to settle the child in.
4. Every effort should be made in the future to provide hospital accommodation that will allow for the admission of mothers and for the reproduction, so far as possible, of homey surroundings familiar to the child.
5. Hospital procedures, painful or otherwise, that may have a traumatic effect on the child, should be strictly avoided unless absolutely essential.
6. It is strongly advisable, within the limits of staffing facilities, for the same doctor and the same nurse to follow through a case to the end, in order that the sense of security necessary to the child may be provided.

7. Visiting as a general rule is strongly to be encouraged, with the proviso that the pediatrician always holds the right of decision in individual cases; fathers and friends, as well as mothers, can be valuable visitors; the value of visits can be enhanced if helpful occupations are found for the visitors.
8. The value to children of long periods in hospitals and institutions remote from home is in many cases open to doubt, and great caution should be exercised before a child is thus sent away. Where it is unavoidable, special allowances might be provided to enable parents to visit regularly. Care must be taken to prevent the child who is without visitors from becoming a psychological casualty.
9. The child also needs preparation for discharge and, in long-stay cases, he may require gradual acclimatization to home contacts and surroundings.

Training

To what extent should the pediatrician be a psychiatrist, or the psychiatrist a pediatrician, and how far should the nurse be familiar with the work of both? The extent and character of additional training that each should receive occupied an important place in the work of the study group.

The varied conditions obtaining in different areas make it impossible to arrive at conclusions that can apply in all circumstances. In many countries, few pediatricians, even fewer nurses, and no psychiatrists are available to care for the child in a hospital. Elsewhere, although there is more efficient control of physical disease, an increasing number of psychological problems have appeared among the child populations and fresh difficulties have to be faced in this field.

These problems can only be solved in the light of a country's own particular needs. The work of pediatric teams and the creativeness of specific local genius may well be impaired by rigid imitation of training methods used elsewhere. Nevertheless, there is much to be learned from an exchange of experience, and certain practices can be usefully put into general use, either in their original form or modified to suit a country's requirements.

The summary of the discussion given in the present section falls into three parts — the teaching of pediatrics, the training of the child psychiatrist, and the training of the pediatric nurse.

The Teaching of Pediatrics

In this first part, Dr. M. J. E. Senn, professor of pediatrics and psychiatry at Yale University, described the development of pediatric training in the U.S.A. and more particularly in the department under his direction. He prefaced his statement with the remark that, only a few years before, he himself had suffered from the same limitations and difficulties that faced many a pediatrician today in other parts of the world. And it still remained to be seen whether his experiment would succeed and whether a careful balance between the skills of physical medicine and the dynamic concepts of psychological medicine could in the end be evenly maintained.

The views of Dr. Senn and the description of the experimental methods in use at Yale over the past fifteen years are given in part below in his own words.

Historical background

The first practitioners of pediatrics were physicians who limited their general practice to children, sometimes combining obstetrics with child care. Their attention was focused on the diseases of childhood, but as the public health movement developed attention was paid increasingly to the prevention of illness and the promotion of health.

With the rise of scientific medicine and increased use of the laboratory for investigation and diagnosis, pediatrics assumed the status of a true speciality. At approximately the same time that scientific methods were being applied in the diagnosis and treatment of sick children, the behaviorist psychologist, Watson, was adapting Pavlov's work on the conditioned reflex to children, showing that they could be conditioned and unconditioned to the fear of animals. These studies influenced pediatrics momentously in that they provided pediatrician and parent alike with new ideas on the rearing of children. Apart from psychologists, physicians, including some pediatricians, began in the early 1900's to show interest in neurological diseases and in the pathology of the brain.

No marked influences from psychiatry became evident until after the first World War, when, with the rise in juvenile delinquency, lay persons rather than physicians promoted the development of psychiatry and started the child guidance movement. However, even as recently as 1930, psychiatry was not integrated with the rest of medicine, and pediatricians saw nothing of value to them in medical psychology apart from intelligence testing. At about that time pediatricians were still teaching parents the tenets of behaviorism, although the parents themselves were beginning to

question and even resist any advice about child care which was rigid, artificial, or mechanical. As with the public health movement in the U.S.A., the impetus for the development of child psychiatry and general psychiatry came rather from lay persons than from medical groups, and two American foundations, the Rockefeller Foundation and the Commonwealth Fund, must be singled out as potent forces in this direction.

Not only was the Commonwealth Fund interested in establishing child guidance clinics and in training child psychiatrists, but by 1935 it was sponsoring training in psychiatry for certain pediatricians, to enable them to become pediatric educators and to explore the possibility of integrating psycho-dynamic principles into everyday pediatric practice. Although interest in broadening pediatrics was not general at that time, there were a number of pediatricians who were beginning to appreciate that, if it was to remain a special branch of medicine, pediatrics must concern itself with more than the physical diseases of children. They were faced with a mounting number of behavior problems about which they had little or no knowledge, and they lacked the skills necessary for their treatment. At the same time a decline in some of the problems arising from physical illness was evident. Infectious diseases were more easily controlled, complications prevented, and the nutritional disorders of infants and children more easily recognized and treated.

The problem of integrating psycho-dynamic principles with pediatric practice

The desire of pediatricians and psychiatrists to collaborate in training and to work with parents and children gave rise to a number of practical problems. Should sufficient child psychiatrists be trained to work as teachers, diagnosticians, and therapists in departments of pediatrics? Should pediatricians be given opportunities to learn from psychiatrists, but continue to practice only within their own field? Or should there be a new specialist called a "pediatric psychiatrist"—a hybrid physician, not quite a child psychiatrist, but with more training in psychiatry than a pediatrician usually receives?

Answers to these questions have not been fully resolved in the U.S.A., though attempts to experiment with each of these approaches have been made. It has been evident for a long time that there will never be enough child psychiatrists to deal therapeutically with the emotionally disturbed child and his parents. The first suggestion, therefore, seems impracticable now and for a long time to come. This means that the child psychiatrist will not be the sole person responsible in the psychological aspects of pediatrics.

Of the two remaining possibilities, the second has seemed a more natural development than the third, for it has frequently proved impossible to differentiate those designated "pediatric psychiatrists" from child psychiatrists. I believe that the well-trained pediatrician must be prepared to provide his patients with comprehensive medical care based on the treatment and prevention of physical disease. He must not only be skilled in the diagnosis and treatment of disease; he must also be alive to the psychological concomitants of physical illness and to methods of dealing with them. Thus, there should be no dichotomy of health and illness, of psyche and soma. Furthermore, he must be interested in the growth and development of healthy infants and children and have the insight and

skill to promote health and prevent illness. A pediatrician who deals comprehensively with his patients will, of necessity, be able to perceive the beginnings of emotional disturbances and, what is more important, will become an instrument in the community to prevent such disturbances.

From the foregoing it will be clear that I advocate the incorporation of many principles of psychological medicine into non-psychiatric disciplines. I believe, however, that the pediatrician should remain a pediatrician and practice within his normal field rather than set up a new branch of medicine called "pediatric psychiatry." This does not mean that I am uninterested in the further development of child psychiatry as an important special branch of medicine. For the purpose of this discussion, however, I would emphasize my feeling that the pediatrician today is particularly well placed when it comes to preventing emotional disturbances or dealing with them in their incipiency.

The experiment at Yale

For the last 15 years I have concerned myself with pediatric education at the postgraduate and undergraduate levels, attempting to demonstrate natural and effective ways of educating non-psychiatric physicians in the principles of medical psychology, and to show that psychiatry offers various skills and approaches capable of sharpening pediatric insight and improving child care. Throughout these years we have tried to cover certain basic topics in our training program.

These have been:

1. Mental (emotional, social, and intellectual) growth and behavior from birth to maturity, in the light of the interplay of hereditary, constitutional, psychological, and cultural forces occurring in the development of each person from conception onwards.

2. The psychological implications of child-bearing, of education, and of child care in health and in sickness, especially in terms of the parent-child and other personal relationships.

3. The psychological concomitants of physical illness and the psychological rôle of physician and nurse in parental guidance and in the medical treatment of sick children and adolescents.

4. Deviant personality structure and psychopathology (especially in psychosomatic disorders) with emphasis on the genesis, prevention, and treatment of emotional difficulties and the so-called behavior problems of all age-groups from birth to adolescence.

5. Opportunities for psychotherapy in pediatric practice, particularly through such commonly used techniques as history-taking and physical examination; the limitations of such methods; the methods of preparing patients for treatment by psychiatrists.

6. The influence of social, economic, and cultural factors on children and parents.

7. The contribution of the social sciences to the improvement of child care.

Our methods of teaching these principles have varied over the years. At first our trainees consisted of pediatricians who had had at least two years' training in orthodox methods at an accredited pediatric center. These post-graduate students had definite teaching posts to return to on completion of their training. They began their learning experience in a psychiatric ward for adolescents and young adults, where they could

see gross psychopathology demonstrated and begin to see the outcome of neurotic and psychotic illness. They also had an opportunity to study the origins of these illnesses and to note whether there had been any basis in infancy and childhood for their development. Clinical work was associated with seminars and supervised conferences about individual patients. The time spent in the general psychiatric clinic varied from four to nine months. After that the trainee took up work in the psychiatric out-patient department and in the pediatric clinic. He continued, however, with his patients in the psychiatric wards in order to get a comprehensive view rather than fragmentary observations.

In the psychiatric out-patient department each student (under supervision) was assigned children and patients who came with problems of behavior of the kind ordinarily seen in such a service. Work with these patients was carried on until the end of the second-year training period, covering roughly a span of 15–20 months. The emphasis here was not on making the trainee a child psychiatrist, but rather on introducing him to persons with problems and on giving him some insight into the nature of these individuals and the effect their problems might have on child-rearing and child care. It also brought the trainee into close touch with practicing child psychiatrists, social workers, and psychologists, enabling him better to appraise their rôle in the diagnosis and treatment of behavior difficulties. Very often this was the first opportunity a pediatrically trained physician had of first-hand contact with a psychiatrist. Concurrently with this period in the psychiatric department the students worked in the pediatric department, particularly the well-baby clinic, the adolescents' clinic, and the general sick children's clinic, both in-patient and out-patient. Efforts were made to keep the case load small, so that adequate time could be spent with each patient, and the cases were followed as long as possible, enabling the student to observe the changes which come with age and maturity. Physically sick children were cared for, always bearing in mind that they were individuals in whom the psychological and physical elements interacted. In our attempt to teach comprehensively and to include the psychological elements we tried to maintain an awareness of the importance of the body, its function, and its anatomy and pathology. It must be emphasized repeatedly that in the teaching of medical psychology to non-psychiatric physicians nothing must be lost which has been gained from scientific medicine in the diagnosis and treatment of physical illness. To insure this as far as possible our method of teaching was to emphasize that the medical and psychological approaches were best made through the traditional medical procedures, namely, history-taking and physical examination.

Although these methods were stressed as fundamental to the study of the patient, whether the problem were physical or psychological, it was also necessary to demonstrate that changes in the traditional methods of history-taking are required in order to appraise a patient as a human being. History-taking must be considered as a form of interview, with important therapeutic implications; further, a thorough physical examination has its therapeutic as well as its diagnostic implications.

These trainees, after spending two years in post-graduate work relating psychiatry to pediatrics, left to assume different positions in public health or pediatric departments; some went on for further training in psychiatry in order to become fully qualified in that field.

Concern was felt over those pediatricians who took on the rôle of child psychiatrist in departments of pediatrics without sufficient training to qualify them. It has been found that the trainee who functions best after his post-graduate experience is the one who continues to be associated with pediatrics in his practice, and who is accepted in a department of pediatrics as a pediatrician. Within this framework he is able to teach growth and development, the meaning of behavior, and the other aspects, doing this safely, without confusion to himself or his colleagues. In order to promote the development of such pediatricians and in order to safeguard them as well as the patients, our training program was reduced from two years to one year. This was accomplished by omitting the training in the department of psychiatry and limiting experience to that of the pediatric ward and out-patient department. In this way, the student is constantly reminded that he is a pediatrician working within the field of pediatrics. After several years of further experiment with a one-year training program, it was felt that the time had come when special programs of post-graduate education in pediatrics for persons desirous of learning about psychological medicine no longer served a purpose. As a result, the Department of Pediatrics of the Yale University School of Medicine has concentrated on making available to every pediatric resident the opportunities which formerly came only to these special trainees.

At the end of a two- or three-year pediatric residency it is hoped that our trainees will have at much understanding of growth and development, behavior, and parent-child relationships as of the physical elements of medicine emphasized in diagnosis and treatment. No matter what the patient, our day-to-day teaching is intended to bring out the mental as well as physical aspect of each case. For example, in ward rounds consideration is given not only to the child's pneumonic processes, but also to the influence of his illness on how he feels, on his behavior, and on his relationship with his parents. In his convalescence we are concerned not only with the resolution of his physical signs, but also with his return to good physical and emotional health and with his ability to join his family and his friends in a fully functioning rôle as soon as possible. In the hospital we are concerned with the psychological management of the physically sick child; we have relaxed restrictions on visiting, included living-in arrangements for some parents and children and care of infants by their mothers, and have provided adequate recreation and occupational therapy opportunities for the bedridden as well as the ambulant patient. Our in-patient rounds tend to be rounds made by groups of persons with different professional interests, including pediatrics, psychiatry, sociology, psychology, and social work; they consist of informal discussions with contributions coming from junior personnel as well as senior staff, the leader being the pediatrician-in-charge.

Another method used at Yale to teach "growth and development" is one which introduces the pediatrician-in-training to the practice of medicine outside the hospital. Each intern, on starting his service, follows the last trimester of pregnancy of a woman who has volunteered to accept him as her pediatrician. The pediatric intern meets the pregnant woman and her husband once or twice to learn the history of the pregnancy and come to understand the couple and their aspirations as future parents. Whenever possible the intern witnesses the delivery and notes

the mother's reactions to her labor and to the birth of her baby. From then on he becomes the family pediatrician as long as this remains mutually agreeable to parents and staff. During the next few months, although the infant and his parents are seen regularly in our well-baby clinic, the intern is also available for home care at times of illness. In this child-care program each intern is under the direct supervision of an assistant resident who acts for him in emergencies when he is not available. Before routine visits the intern and assistant resident are briefed on what to expect and how to deal with certain problems which may arise; if, in the course of the visit, active supervision and consultation are required a senior member of the staff is called in. After these visits there are staff meetings for the entire pediatric resident staff, senior and junior, as well as others, such as child psychiatrists, psychologists, and social workers in the department of pediatrics. Frequently one or two of our nursery school teachers are also present. In these sessions patterns of behavior and growth and development are discussed, using the cases as illustrative material. This method of presentation is the more valuable as the children are known to the pediatric trainee and these aspects of pediatrics are better brought out and grasped than if presented in a didactic form.

An important section of our program consists of training in the pediatric out-patient department. Under the leadership of a child psychiatrist, pediatricians in training and medical students gain experience in dealing with ordinary child patients coming to a general pediatric service. Patients with minor behavior difficulties are not referred to psychiatrists; they are kept under the guidance of the pediatrician in training and his supervisor, who attempts to demonstrate how the non-psychiatric physician may deal with them adequately and safety. The child psychiatrist in charge of this training is assisted by a social worker skilled in medico-social and child-guidance work. They are joined in conference from time to time by a psychologist, particularly when mental testing has been arranged. Bi-weekly conferences in the clinic are led by this multi-discipline team so that the pediatrician in training, the medical student, and nurses may together learn how to work effectively with all patients. In this way the out-patient service in the department of pediatrics becomes more than a mere clearing-house through which patients pass to special clinics.

Towards a new synthesis

Competence in the care of sick children is no longer enough, although that is an assumed requisite, nor is a formal knowledge of growth and development. We have attempted to broaden the field of interest so that the pediatrician can both contribute to and learn from many other professional and lay groups which also care for children's needs. We feel that one of the obligations of an academic department of pediatrics is to synthesize and correlate the information and techniques developed in these other disciplines and to present them as a synthesis to the pediatrician in training, so that he can employ it in a helpful and practical manner.

Discussion

It was generally felt that Dr. Senn's method of training was highly desirable. A few members of the group from other countries had already started somewhat similar training schemes in their own hospitals, though they were as yet in a very experimental stage. Others pointed out that in their countries there were no psychiatrists trained to work with children, and at the same time their pediatricians had no knowledge of psychology. In view of this they were faced with an acute problem when it came to initiating a training program along the lines indicated by Dr. Senn.

The discussion, therefore, developed around the elementary principles upon which an *ad hoc* training program could be built.

The Technique of Consultation.—The first and most important factor that will influence the student, nurse, or pediatrician in training is the attitude of the head of the department, the professor of pediatrics. It is only if he fully appreciates the causes of emotional disturbance in the child and is cognizant of the stages of emotional development that a similar awareness can be transmitted to those who learn from him.

Students, at an elementary level, can acquire much that is of value through the method described by the late Sir James Spence as the "technique of the consultation." They watch the experienced pediatrician and listen to his way of speaking to the child in a conversation that may appear quite foolish to the uninitiated; they note his way of establishing initial contact and learn that the child is not a miniature adult — that he must be treated differently, as befits his age and understanding. The student also has to learn that the treatment of the child starts with the initial interview, just as in the work of a surgeon rehabilitation begins with the arrival of the ambulance. Every gesture of the pediatrician plays its part in the success of the treatment.

The old method of history-taking, where the chief complaint is conscientiously noted, inquiries are made into the history of the present illness, and the family history obtained in due course, is now being abandoned for a much more permissive technique. Experience has shown that histories obtained by rigid questioning often amount to little in terms of accuracy and give but small indication of family relationships.

The newly-qualified doctor tends to treat his patients unfeelingly and mechanically; being as yet unsure of himself, he is afraid to depart from regular procedure and adapt himself to the individual needs of his patient. If, on the other hand, he becomes aware of the existence of these problems through working in a good pediatric department, a point is sometimes reached where he is fearful of doing anything to his patients in case he causes some psychological trauma. He has to combine humanity and sympathy with acceptance of the fact that painful procedures are at times inevitable in the practice of good medicine.

It is one thing to encourage a student pediatrician to establish good relationships with children; some do so intuitively, while others must acquire the skill through an intellectual approach, studying and learning from their seniors. It is, however, another matter to lay before the student the vast area of scientific knowledge about emotional development, cultural norms, and family life. Nevertheless, even where there is no immediate possibility of organizing a training program in this field, it is possible to cultivate a new approach to the child, and this can pave the way to the introduction of such a program at a later date.

The Comprehensive Approach to Training.—In 400 B.C. Plato complained that modern doctors were splitting the psyche from the soma. Today, it was noted, doctors are not only dividing, but even fragmenting, the human being.

There is, moreover, a tendency to ignore the psyche. How many universities will offer a professorship in pediatrics to a man whose interest lies at least as much in studying the behavior and emotional development of the child as in the physical and pathological aspects?

It is to be regretted that research workers in the field of human behavior often cut themselves off from the actual milieu for which they prescribe. There are two sets of standards — one in the scientific field of the study of human behavior, another in the practical field of medicine and psychiatry. While this gives the research worker a certain detachment that may have its value, it also narrows the field and limits the application of his work in collaboration with other professional people.

Obviously, one individual can no longer contain within him-

self a fraction of the knowledge which exists about the working of the mind and of the body or the sum total of the individual's needs. No matter how these needs may have varied from age to age and from place to place, Plato's man has remained fundamentally the same, a simple being. He may be physically a little taller and mentally more alert, but his heart, his brain, his liver are in the same relationship to each other, and his feelings of love and hate, fear and security, remain much as they were.

Therefore a comprehensive approach to the individual patient is required. This can be achieved by a form of team-work designed to synthesize the fragmentary disciplines that have developed in modern medicine. But it also demands a broader knowledge and understanding on the part of the physician primarily concerned with children.

The methods outlined by Dr. Senn have shown how this can be brought about. There is little doubt that group work and group discussion result in far more valuable all-round experience and knowledge than didactic lectures or formal ward rounds, during which the head of the department instructs a vast gathering of students, interns, and members of the nursing staff.

Much more could be taught if inefficient teaching routines were dropped. This does not mean a clean break with the past, but more carefully planned teaching techniques and a better appreciation of what the student ought to learn. In fact, where there is no psychiatric team working in the children's hospital, the pediatrician in training, after making a study of the normal child, should later spend a year in a child psychiatry department, a child guidance clinic, or both. The purpose of this would not be to produce a hybrid "psychopediatrician," but to enable him, for example, to recognize a case of schizophrenia in its early stages and to be familiar with behavior problems and anxiety states. It is also desirable for the pediatrician to have access to some theoretical knowledge of psychoanalysis and first-hand contact with the practical problems involved.

Finally, the pediatrician must know what task each different expert can accomplish, which aspect of his patient pertains to the psyche and which to the soma. He must not merely be concerned with sick or delicate children, but with the entire

development of the normal sturdy specimen of humanity. He has to equip himself to be the "synthesizer."

Conclusion.—In order to achieve the all-round treatment in hospital that is necessary in the best interests of the child, the specialized training of the pediatrician should be considered in the light of the following points:

1. The principle that the physical and mental aspects of child health cannot be separated should be inherent in the whole training program.
2. This principle should be demonstrated through teaching methods where theory and practice are integrated in the greatest possible degree. To this end a critical review of a number of long-established teaching routines is desirable.
3. The pediatrician, as the specialist primarily responsible for the child's treatment, should either do his training in a children's hospital where he can work with a psychiatric team or, in default of this, spend at least a year in a child's guidance clinic, so that he may acquire a general knowledge of the child's emotional development against the background of family life and cultural norms.
4. Where resources are not available to establish a comprehensive program of training along these lines, much can still be done through the example of heads of departments and the use of a "technique of consultation" to promote a more comprehensive approach to the child and prepare the way eventually for a more fully organized training program.

The Training of the Child Psychiatrist

The basic clinical training of the child psychiatrist did not come under discussion. It was assumed that this would include mental-hospital experience as well as practical knowledge of psychological and neurological medicine, possibly acquired in the out-patient department of a general hospital. The length of time spent on this training naturally varies in different countries. Experience with mentally deficient children is not always regarded as essential in the psychiatrist's training. The study group, however, considered that this was an important part of his work and that appropriate training should be provided.

If it be assumed that these essentials are covered, there are other aspects of a psychiatrist's training which at times appear to be entirely omitted from the curriculum. One frequent deficiency in training is a lack of experience in pediatrics and the life of a children's hospital.

All were agreed that a child psychiatrist's training should include at the least a year's pediatric experience. But what kind of experience? During his period of training he may well acquire skill in the treatment of diabetes, the endocrine disorders, or blood diseases, but unless he remains in very close contact with pediatrics he will soon become out-dated. It is much more important for him to work in a pediatric center where he can be taught the dynamics of growth and development and learn at first hand about the infant and child in their different phases and reactions to illness. Moreover, the psychiatrist needs experience with children in the nursery school and in family surroundings, as well as in the hospital. Ideally, he should have some grounding in this work as a medical student. Later practical training in this field could be organized during his period of attachment to a pediatric department. This phase will, therefore, need very careful planning if it is to be of real value to him.

There is, further, a need for the psychiatrist to be well versed in cultural anthropology and sociology. He must have a sound knowledge of the family and cultural life of people around him if he is to bring the full value of his discipline to the work of a pediatric team. Despite a high level of technical education, doctors often betray ignorance in these matters. In the case of psychiatrists this is only now beginning to be modified through pressure from other members of the psychiatric team, the social workers and the psychologists, so that they are coming to accept the need for a broader outlook. Here it may be apposite to note that the differences in social and cultural background from one country to another make psychiatry a difficult discipline to transmit, and that training in one country does not always suit the needs of another.

Psychoanalytical Training.—Should psychoanalytical training form a part of the curriculum? One member of the group posed this controversial issue in the following way:

> "I think we should demand the highest possible standard of training for the psychiatrist since, in this field, all the information which we pediatricians, nurses, and eventually the general public, are going to have, must needs come from him. For that reason I feel we should emphasize the need for the psychiatrist to have an extensive training in dynamic psychology, a discipline that has developed from the findings of psychoanalysis. We must recognize that we are living in a post-Freudian age and a great deal of what we consider common sense now was new and sensational 40 years ago; otherwise we are refusing to accept something which has influenced the whole of our thought in modern times."

This led to the discussion of two points. How far does psychoanalytical theory influence the practice of child psychiatry? And, what psychoanalytical training should the psychiatrist have?

As far as the first is concerned, there seems little doubt as to the need for psychoanalytical knowledge in the practice of child psychotherapy. A certain number of children need authentic, orthodox analytical treatment. This takes a great deal of time and should only be given by highly skilled specialists. But the psychotherapeutic treatment of most children who attend child guidance clinics, although in the orthodox sense not psychoanalytical, is largely based on this knowledge and the study of interperson relationships that is its complement.

Can this knowledge be obtained by theoretical teaching and observation?

In part it can. It is not unknown for psychiatrists, pediatricians, and social workers to carry out their work as though engaged in an apostolic mission; they often tend to be too protective or to identify themselves too much with their patients. Psychoanalytical training teaches the psychiatrist to maintain an inner detachment, allowing him the freedom necessary to a wise handling of each case. It helps him to a better understanding of the child's behavior, of the development of the mother-child relationship, and enables him, in his relationship with children and parents, to maintain an attitude conducive to the maximum therapeutic success.

The growing importance of group work and group therapy with children, parents, and students, where a clear picture of interperson relations is essential, gives psychoanalytical training particular significance.

However, a knowledge of psychoanalytical theory and observation of its practice cannot replace actual experience through personal psychoanalysis. In every country where psychoanalytical training is given it is a recognized rule that the trainee must undergo personal psychoanalysis as an indispensable part of his training. This is not merely a routine procedure. Through this experience the trainee learns how he reacts in all the vital situations in which he may be placed and how he tends to project his feelings. It makes him aware of influential hidden factors in his own past life, and this, in turn, leads him to understand many things about children with which he will be concerned later on.

In present-day psychoanalytical treatment greater emphasis than ever is being placed on the immediate interperson relations between the psychoanalyst and his patient. A prolonged study of this nature enables the future psychoanalyst to understand what is going on between himself and his psychoanalyst. Strongly positive and strongly negative feelings are aroused (transference and counter-transference), the proper understanding of which is of great significance alike for satisfactory team-work relationships and for successful therapy.

The question thus arises whether every child psychiatrist should undergo personal psychoanalysis in training. In many countries this will be quite out of the question, since no trained psychoanalysts are available. Even in countries where psychoanalysis is practiced by well-trained specialists, the number available to give training analyses is limited.

There are some in all countries for whom the experience will be the opposite of therapeutic. A psychoanalyst skilled at his work does not take on anyone for treatment or training without distinction. He will first study the personality of his patient and will undertake an analysis only if he is confident of its therapeutic value. This does not mean that some child psychiatrists, who for any reason have not undergone personal analysis, cannot be satisfactorily trained in the psycho-dynamic principles founded on psychoanalysis. It was generally agreed that all child psychiatrists should receive this training.

Practical Training Difficulties.—A difficulty inevitably arises when it comes to fitting this manifold training program

into a period of reasonable length. Nevertheless, the problem does not seem insurmountable and the following suggestions may go some way towards their solution:

1. Teaching on common family relationships, general development, the more usual kinds of emotional disturbance, and the effects of illness on people, together with some general anthropology and sociology, are all subjects in which every medical student should have some grounding. If they could be included in the student curriculum, the burden would be lessened in the post-graduate stage.
2. Psychoanalytical training, which normally extends over three years, could be carried on simultaneously with other facets of the trainee's work, including his period of pediatric training.

Conclusion.—To sum up the feeling of the study group, it should be a part of the child psychiatrist's specialist training to have:

(*a*) a knowledge of the cultural patterns of behavior and emotional development;
(*b*) carefully planned training in pediatrics;
(*c*) an ability to diagnose and treat both adults and children as a result of his psychiatric and neurological training; and
(*d*) in the majority of cases where feasible and reasonable, experience of personal psychoanalysis, in order to be able to use and promote an understanding of psychoanalytical principles.

It would be unfortunate were the child psychiatrist to aim at becoming a hybrid "pediatric-psychiatrist." The extent of training and experience advocated would make big demands on the trainee. At the same time it must be recognized that child psychiatrists, like most specialists in other branches of medicine, need to spend a number of years in training if they are to be adequately qualified and competent. In the words of one of those present:

> "The problem of mental illness in many countries of Europe today is of similar magnitude to that of physical illness in tropical parts of the world. There is an acute sense of the need to have specialists to deal with this. There is intense pressure from the lay public. The possibility of providing qualified help is not good. It seems important that the rela-

tively few specialists there are, besides being clinicians, should be given the chance to act indirectly through the training of future doctors. For this task they themselves need the best possible training and qualifications."

The Training of the Pediatric Nurse

In view of the essential need for team-work in pediatrics and child psychiatry and the important rôle of the nurse in this work it was felt that her pediatric training should also be reviewed.

Pediatric Nursing at Yale.—As a preliminary to the discussion, nursing education at Yale was described. Here students are recruited from two sources. In one case they are chosen by the School of Nursing from applicants with two or three years of university work behind them, who, on completion of their course, receive an academic degree, that of bachelor of science in nursing. In the other they are high-school graduates who come direct to the School of Nursing attached to the hospital.

Candidates must be in good physical health and, as far as can be determined, emotionally stable. Emotional stability is not always easy to assess accurately, but throughout their training it is borne in mind that they are subjected to experiences which may well be upsetting and that they should have ready access to help in case of need. This is normally provided throughout their training in regular meetings with the faculty, where they can talk about themselves, their plans, and so on. Occasionally, a nurse is found in this way to be mentally sick or emotionally disturbed. In such cases her training is suspended and she is given help in obtaining psychotherapeutic treatment.

The three-year training covers both theoretical and practical work, and during the second year students spend time in the pediatric department—usually six months, or more if they wish to specialize. During their pediatric training they receive lectures from pediatricians and discuss the physical care of children, the common diseases, their diagnosis and treatment. They are observed as they work with patients and are trained in "growth and development."

At one time there was a series of six two-hour sessions in this subject, the infant and child being described from the

standpoint of their development, with special reference to the findings of developmental examinations. This approach, however, did not arouse the interest of students; the knowledge was not related to their practical work, and it gave them no understanding of their patients as human beings. It proved, in fact, too mechanical and was abandoned.

Student nurses are now placed for a short time, about two weeks, in a nursery school for healthy children where, under supervision, they observe the children. Each observation period lasts for three hours and is followed by a session when the observations are discussed and the students questioned about what they have seen.

In addition each nurse spends two weeks as a play nurse (not wearing her hospital uniform), working with the full-time play worker in the wards. She is assigned one patient each day and keeps detailed notes to help her to look, to listen, and to record. She helps the child at meal times, plays with him, and puts him to bed. When working in a clinical rôle as a "bedside" nurse she accompanies the medical staff on their daily round and is encouraged to ask questions and join in the discussion as an important member of the team.

One of the most valuable features of the training has been the weekly conference of all the student and graduate nurses attached to a ward. Here they talk about their special problems and ask why one child will not stay in bed or why another has tantrums. Students are very receptive to suggestions made when they are personally involved in situations such as these; they are always asked to look beyond the obvious behavior and ask: "Why is this child acting in this particular way?" Emotional development is also studied, and it is brought home to them that in ministering to children physically they are also ministering to them emotionally, that every action has its meaning to a child although he cannot convey what he feels in words.

The theoretical course gives the nurses a more organized picture of emotional, intellectual, and social development as an inseparable complement to physical development and as having an effect on physical care.

At the beginning of their course they meet the professor of pediatrics in charge of the department. They are told by him of the stresses and strains they may have to face; how they

will probably react to their colleagues, their patients, and the parents; they are advised to behave spontaneously and not to feel they have to be impersonal in their care of infants and children; they are encouraged to pick up the child and caress him if they want to. They also know they can always see the professor of pediatrics in person if they want to discuss a problem or difficulty.

One important aspect is that of planning the training to fit in with the teaching of the senior nurses and supervisors. Post-graduate courses are arranged when asked for by senior nurses, and usually take place in the evenings in the home of one or other of the doctors. Here, in a friendly, hospitable atmosphere, nurses can discuss their problems and feel at ease in talking about their difficulties over the children, the hospital, or visiting hours. Whatever they may want to discuss more fully with the medical personnel, they have the opportunity to take it up quite frankly. This attention to personal difficulties during the nurses' training has brought its reward in that an increasing number of students ask to work in the pediatric department.

General Versus Specialized Training.—At Yale, nurses spend a considerable part of their second year of training in the pediatric department. On the other hand, a special type of nurse, the registered sick children's nurse, has been working in the United Kingdom for over 20 years. These nurses are recruited at the age of 18 and take their state examinations after three years' training at a children's hospital, without any experience in adult nursing. In its original form the Nurses' Act of 1949 would have provided for the abolition of all special nursing diplomas except for the midwife and the mental hospital nurse. As a result of representations, an exception was made for the sick children's nurse, but with the clear understanding that her training would be reconsidered at some future date and that the decision was in no way final. In order to meet the situation a comprehensive type of training has recently been established in London and other centers, as an experiment, whereby student nurses spend their first year in a children's hospital and their second at a hospital for adults, returning subsequently to the children's hospital to take their state examination, followed by

their examination for the children's register after one more year.

The point at issue is that a certain type of girl is drawn to child nursing and has no wish to nurse adult patients. If the sick children's diploma were abolished a valuable group of students might be lost. It has also been found that the student who chooses the care of sick children as her vocation is often far more receptive to the ideas of comprehensive pediatrics, including its psychological aspect, than a person who comes to pediatric nursing through a year's post-graduate training following three years' general nursing. If nurses are to be imbued with the sort of approach that is desirable in a children's hospital they must, from an early stage, come under the influence of its atmosphere. The same opinion has been formed from experience in Italy, where there are now two schools of training for nurses specializing in work with children. Those who train with adults are found to be less understanding of children's needs, whereas first-class results have been obtained by recruiting girls of 18 who have already had some experience with children in nursery schools or have had some higher education, and who wish to devote themselves exclusively to children.

Shortage of Nurses and Their Status.—Many members deplored the acute shortage of nurses in their countries, and urged that they should receive a better salary and be given a more attractive social status. Otherwise, it was argued, a vicious circle might develop, with understaffed hospitals, overworked nurses, a steady drain on the profession, and recruiting difficulties. In such circumstances nurses would be less receptive to a comprehensive psychological approach which might involve them in even further duties.

By improving the nurse's status, by accepting her as a full member of a team, drawing her into conferences and discussions, and improving her training and pay, there is every ground to hope that the vicious circle can be broken.

In Italy, with the improved status of pediatric nurses, who now receive a state diploma, the number of applications has been almost three times the number of places to fill.

In some countries the shortage of nurses is being overcome by the substitution of auxiliary nursing personnel for some of the functions ordinarily carried out by nurses. For example,

mothers or members of the nutrition department feed the babies more often than the nurses. During the late war, individuals not qualified as nurses were found to be highly efficient in the operating theater and are still so employed. The war has shown that auxiliary personnel of either sex can be successfully trained as assistants to surgeons.

Courses consisting of a year's training have also been organized for women not otherwise eligible for the profession to become paid "nurse-assistants." Mothers who have brought up their families make excellent recruits. The scheme has proved very successful and "nurse-assistants" bathe and feed the children and even give them simple medicaments, thus freeing a large number of nurses who are so urgently needed to tend sick children.

Role of Male Nurses.—In order to help overcome the shortage of nurses would it not be possible to recruit men? Might not the adolescent boy with a long illness or the small girl who misses her father gain from the care of a male nurse? In many parts of the world male nurses have proved their worth. An instance was given, in discussion, of a large hospital in Kenya where the pediatric nurses are all African males, working with European head nurses. For a number of years African women nurses have been employed but have proved less successful with the children than the men. This may be due to a different social and cultural pattern of life. No doubt, in most hospitals there is sufficient medical staff to provide father substitutes; but the question should be considered further, both from the standpoint of the shortage and in the light of the nurse's rôle.

Psychological Aspects of the Nurse's Training.—Consciously or unconsciously the psychotherapist tends to become possessive about his patients unless steps are taken during his training that will help him to combat this attitude. In the same way, the nurse tends to become a parent substitute, a pleasurable rôle and one which she is apt to guard jealously. Nevertheless, the mother, however far away she may be, guards her rôle even more jealously.

The subtleties of interperson relationships have to be conveyed to the nurse; there are a number of psychological phenomena she must understand if she is to achieve mature fulfillment of her rôle. For example, she will not be aware

of the phenomenon of regression in a child unless she is given insight into this. A child may not behave at all according to his age; he may be a four-year-old in his psychological behavior one day, and three days later behave like a seven-year-old. Although such reactions are to be expected on hospitalization, they are, nevertheless, not at all kindly tolerated in some countries where the child who has regressed and become infantile during illness is regarded almost with hostility and talked of with contempt.

A further example is the phenomenon of transference, where the child, needing an object to love in his immediate surroundings, forms a strong or violent attachment to the nurse in charge of the ward. This situation may give the nurse a great deal of pleasure; she becomes possessive about the child or sees it as flattering to her skill as a nurse, without understanding it in terms of the child's needs. Even more when the child becomes hostile the nurse must be helped not to feel it as a personal affront. She must be taught to understand it in the light of the child's psychological background.

An understanding of these situations can best be grasped through the teaching and example of a humane doctor. It is more easily achieved during training than later, when the nurse holds a more responsible position. If, when in charge in the ward, she is told that the way she is behaving is bad for the child, her personal pride may seem at stake and she will be less ready to accept what appears as a reflection on her work. It is not so difficult at the training stage to explain the pitfalls and say: "It is very easy as a nurse to want to take a child away from a mother, because you like children." She is then more likely to accept the implications of her special rôle, to assimilate new ideas, and to act on them at a later date. It is also important for a nurse to have interests and ties outside her work, as these make her less likely to become an aggressive mother substitute.

Reorientation of Trained Staff.—Perhaps the nurses least easily won over to the more individual and human approach are those whose training and experience have steeped them in routine procedure, especially those who have worked exclusively in a surgical ward. It is important that the surgeons working with children should give a lead in modifying procedures and attitudes. In this connection, most members felt,

it is preferable not to isolate surgical from general pediatric nursing.

The rigidity of procedure in hospitals for infectious diseases, where the nurses have a host of regulations to enforce, was also deplored by the pediatricians. How necessary, they asked, are a great many of these? Nurses should be given the opportunity to let in more warmth, and so help obviate the psychological traumata so easily inflicted in this restrictive atmosphere.

Conclusion.—To sum up the general discussion, the importance of the nurse as a member of the pediatric team was unanimously stressed. A number of clearly defined points on which there was wide agreement emerged from the discussion:

1. Nurses working with sick children should have had a major part of their training in a pediatric department.
2. Special attention should be paid during the pediatric training to the psychological aspects of a nurse's work, and she should be given the opportunity to participate as a fully responsible member in the pediatric team.
3. The status and pay of nurses in many instances is grossly inadequate and this is responsible for short-staffing and overwork. Only when this situation is remedied will nurses have time to consider the full psychological implications of their rôle.
4. There are various practical measures for alleviating the shortage of nurses, among them the substitution of auxiliary personnel for some functions that need not be carried out by nurses and the short-term training of nurse-assistants for the same purpose. The question of recruiting male nurses deserves careful consideration.
5. In many hospitals rigid regulations and the approach that they inevitably engender are detrimental to the tremendous contribution the nurse could otherwise make to the work of the pediatric team. A progressive and judicious relaxation of such regulations could greatly assist in promoting a new and more effective approach to pediatrics. Coercion is never successful in winning people over; all the members of the pediatric team must work together to humanize hospital care; they must

believe that hospital procedures can be usefully changed and understand why those changes are necessary.

Coördination of Pediatric and Psychiatric Services

The pediatrician trained in comprehensive pediatrics is alert to the many psychological factors to be studied when treating a child. In some cases he will feel competent to undertake all that is necessary, whether physical or psychological, but in others his knowledge of emotional disturbance, of anxiety states, and of behavior problems will lead him to call in a psychiatrist to give specialized treatment.

Apart from referring a child for therapy, he will at times require the *ad hoc* opinion of a psychiatrist about children in his wards, as he would that of the surgeon. However, in fairness to the psychiatrist it should be remembered that he can rarely give an "on-the-spot" opinion, since an accurate psychiatric diagnosis depends on prolonged investigation of the many psychological aspects of the case. Although he may know at once when a child is seriously ill, and recommend full investigation and treatment in a psychiatric department, it is not always easy to give an immediate opinion in borderline cases that may remain the responsibility of the pediatrician.

These considerations raise the problem of coördination between the pediatric and psychiatric services from the curative and from the preventive standpoint. As a basis for discussion the following case was presented.

Coördination in a Psychosomatic Case

Barbara, aged 11 years, first started to have attacks of asthma when she was nine months old. There was only one other case of asthma known in the family, three generations back.

Her attacks were associated with acute upper respiratory infections and continued after these had cleared. She first went into a hospital at the age of two years, but various treatments proved of little help. At three years her tonsils and adenoids were removed. Later, when four, she was admitted to another children's department with bronchopneumonia and on recovery from this was sent for six months to a sanatorium in the mountains.

It had been realized on her admission that she was difficult to manage, emotionally unstable, and at times very aggressive, but as the psychiatrist was working under considerable pressure a consultation was postponed until it could be seen whether a change of environment would prove beneficial. As this produced little improvement in her condition the psychiatrist saw her and her parents in consultation.

The psychiatric interviews revealed that the child's home life was full of tension. The father was a weak man who reacted to stress with headaches and vomiting.

The mother, born out of wedlock, had herself had a disturbed psychological history, and was lacking in self-confidence, though ambitious and conscientious.

Both parents had sought to force Barbara into independence when she was barely three, neither had given her the security or affection that she needed, and they were quite unable to cope with her illness.

She was admitted to the psychiatric unit for therapy, during the course of which she expressed her longing for a more affectionate response from her mother. At times she was extremely hostile and aggressive, but was allowed to express these feelings; at others she was filled with anguish and remorse. During this period her mother also received psychiatric treatment and gradually developed sufficient understanding and confidence to have the child at home for longer and longer periods, a marked improvement being shown in the relationship between the two.

As the years passed a deterioration occurred in her chest condition, although there were longer intervals between her attacks of asthma. Psychologically she remained in a happier state, adjusted herself to her illness and was amenable until recently when, with the onset of puberty, she again became depressed.

At this stage she and her mother asked for further psychiatric help.

The salient features of the case were, in the first stage (up to six years of age), emotional instability accompanied by a chronic asthmatic condition despite all efforts at treatment; the fact that she was so unmanageable was a strain on the pediatric department.

In the second stage (from six to 11), when the psychiatrist had been called in and psychotherapy was given, there were less frequent asthmatic attacks though the chest complications grew more serious.

While it was not possible to establish how far the psychiatric treatment had affected the physical aspects of the case, the psychiatrists concerned believed that the parents were given a different conception of themselves, their girl, and her disease, and it became possible for them to manage her through these exceedingly hard years.

When Should the Psychiatrist Be Called In?—In Barbara's case the psychiatrist was not consulted until an advanced stage had been reached. Assuming a psychiatrist to be available, would it be right to lay down a rule that a child should be sent to him only if physical treatment had failed to relieve the symptoms? Certainly, a pediatrician's training ought to enable him in a great many cases to calm the parents' anxiety

and to exert a beneficial effect on the child, but there is always the danger, when treatment is based purely on symptomatology, that this may not bring more than superficial results.

A psychiatrist cannot determine what therapy to undertake from symptoms alone; he has to consider the case in its entirety. He must know about family relationships and the home environment, and understand something of the child's reactions to these and to his illness before he can tell whether to recommend psychological treatment or not. The case of Barbara illustrates the impracticability of dividing diagnosis and therapy into two stages, one the concern of the pediatrician, and the other where the psychiatrist is called at a relatively late stage in treatment.

Thus, whenever the case is likely to be chronic and emotional factors appear to underlie it, it would be wiser to call in the psychiatrist at the point of diagnosis. It is not enough for him to take action at a later stage. A comprehensive diagnosis is the first major step in treatment. Had a psychiatrist, in Barbara's case, been consulted at the outset, it is possible that the physical therapy might have been more successful. At the least it is probable that the pediatric department would have been able to treat a far more manageable child.

Early Recognition and Preventive Measures.—In the case under discussion irrevocable damage occurred at an early stage. What solution is there for the many similar problems of this kind that are continually arising?

The answer surely would lie in preventive measures. Had this mother received adequate help when her child was still an infant it is possible that much suffering and distress might have been averted.

The preventive services, however, are in many cases still ineffectual, and the shortage of psychiatrists must be borne in mind.

In Sweden and the U. S. A., for example, asthma is so common that it would be impossible for the available psychiatrists to give consultation in all cases.

Pressure of work creates a vicious circle which would be alleviated, in part at least, if early recognition of psychiatric cases could be more widely assured.

Here, an illustration of what could be done was given from a polyclinic for asthmatic cases in Helsinki. At this clinic a

psychiatrist and a social worker have been appointed as members of the staff to see all cases and give them out-patient treatment whenever investigation justifies it. The results have been most satisfactory.

Other methods, too, can help to insure early diagnosis and thus obviate time-consuming treatments. Several pediatricians referred to the "multiple rounds" described by Dr. Senn, and also practiced in their own wards with psychiatrist, social worker, and psychologist in attendance. These have been found of increasing value, not only in helping the pediatrician in his work, but in enabling the child psychiatrist and other members of the team to keep in touch with problems of physical medicine.

If a full-time psychiatrist is appointed to work with the team he can always be present and act as assistant to the pediatrician, both in the out-patient department and on rounds; if, on the other hand, he is appointed as a part-time worker he will be able, as in one London pediatric hospital, to go round the wards once a week with the resident doctor and discuss with him any problems that arise. In this particular hospital he also does a full ward round once monthly with a physician and discusses points or makes suggestions regarding the diagnosis, treatment, or general handling of children. This flexible and informal arrangement has helped towards obtaining early recognition of psychological problems, and has also been useful in reassuring the pediatrician when other children, about whom he has doubts, do not require psychological treatment.

In another instance, at Oslo, the psychiatrists go round the wards twice weekly with the senior pediatrician, who discusses with them any cases he considers in need of psychiatric help. Once a week the psychiatrists see the new admissions to the pediatric wards and give general consideration to the case of each child. Every other week a joint staff conference takes place, attended by pediatricians and psychiatrists, where cases of special concern to the latter are discussed and decisions made as to treatment and responsibility for their future care.

Coördinating the Work of Two Departments.—The rôle and status of the psychiatrist and his relations with the pediatrician are of the utmost importance in the coördination of

their two services. Should the psychiatrist be a member of the pediatric team—an assistant to the pediatrician—and in charge of a closely related child psychiatric unit as, for example, in Stockholm? Should the child psychiatric department be part of an adult psychiatric department as in Paris? Should the unit be independent, as in Groningen, where it is near both the pediatric and adult psychiatry departments, and is easily accessible to both?

While child psychiatrists should be competent to treat adults as well as children, in certain cases where there is a suicidal or grossly disturbed parent needing institutional care, treatment by "adult psychiatrists" will be called for. This is doubtless a point in favor of some association with the adult psychiatric department.

The pediatricians were strongly in favor of having a child psychiatric team closely associated with the children's department, in order to maintain the link between the two disciplines. The psychiatrist would then attend staff meetings, work in the hospital and its out-patient department, and be more readily available to make decisions. He would be in closer contact with the medical and nursing staff and be able to exert an over-all influence.

The child psychiatrists, on the other hand, made the point that a completely independent department was essential in many cases. It should, ideally, be as near as possible to the hospital, but its independence from the pediatric department is necessary because the child psychiatric clinic has an atmosphere and is conducted in a way that is peculiarly its own. It is necessary to have a more relaxed atmosphere than can possibly be achieved in a children's hospital.

The eccentric behavior of disturbed children—the overactiveness of some, the withdrawn attitude of others—has to be tolerated during psychotherapeutic treatment in a way which may cause havoc in an ordinary pediatric out-patient department. This may apply only to those relatively few children who are seriously disturbed, but they need the appropriate treatment none the less.

A major part of the psychological work with children takes place in child guidance or similar clinics, and it is only during the last few years that pediatric departments have opened

their doors to the psychiatrist. Many cases normally seen in child guidance or similar clinics have no need to be associated with a pediatric department.

The great majority of children with behavior problems and anxiety states are sent to these clinics. Most of them are physically healthy, in spite of opinions which may have been expressed to the contrary, and they seldom find their way to hospital. Sometimes, however, family doctors and parents are happier to make the first contact through a pediatrician who will then refer the child, if indicated, to the psychiatrist.

There is the difficulty that when the psychiatrist sees a child in the hospital, especially in the absence of the parents, he is seeing him in an artificial environment which, strictly speaking, is contrary to good psychiatric practice. Consequently, he may well fail to get the true picture he requires. Moreover, the hospital atmosphere, in giving a temporary sense of security, may obscure the nature of the child's anxiety. This again brings out the need for the psychiatric unit to be located independently of the pediatric department.

Ideally, the solution would seem to lie in the psychiatrist's assisting the pediatrician for part of his time, not only to give of his expert knowledge, but also to remain in touch with the atmosphere of a children's hospital and know at first hand what the child is experiencing.

For the rest of his time he should be able to work with his special equipment and special techniques under different conditions and in a different atmosphere.

An arrangement of this character would save him from his too frequent tendency to isolate himself in his clinic. On the other hand his work at the clinic would prevent his becoming too deeply immersed in the specific type of problem which is met with in a children's hospital.

Conclusion.—The main points on which there was a general consensus were as follows:

1. Whenever the pediatric department has to deal with a chronic disease and emotional factors appear to underlie it, it would be wise to call in the psychiatrist at an early stage.
2. Ideally, the adoption of preventive measures in infancy by the pediatrician, the family doctor, health visitor, or maternal and welfare services would be the best means

of avoiding the development of serious psychiatric illness.

3. Failing this, much can be done through the coördination of pediatric and psychiatric services to promote early recognition of such cases.
4. Both the above approaches could do much to alleviate the shortage of trained psychiatrists and the pressure of work on those available.
5. The child psychiatrist should advise the pediatrician, much in the same way as the radiologist or the pathologist does. The pediatrician would then be responsible for making a synthesis of the sum total of findings and for making the final decisions.
6. In cases where psychotherapy is necessary the psychiatrist should assume full charge of this, though continuing to collaborate with the pediatrician wherever that is indicated.
7. Where the child psychiatric unit is an independent one, it should be situated near the pediatric department, so that a two-way exchange may be readily brought about.

The Psychiatric Team.—What should be the function of a psychiatric team, and of whom, in addition to the psychiatrist, should it consist? In a number of countries it includes at least two other members, the psychologist and the psychiatric social worker. Recently, especially in university training centers, a number of teams have included sociologists and anthropologists and many of them add a non-medical psychotherapist and a speech therapist.

Before reporting the discussion on this problem and the case on which it was based, a brief outline of the training and rôle of psychologist and psychiatric social worker in one of the countries concerned may be of value.

The Training of the Psychologist in the United Kingdom.—The psychologist is expected to have an academic qualification in his subject, preferably at the honors level, and not as a subsidiary subject to philosophy. The academic course is a scientific one, concerned with the study of human behavior. It usually consists of a three-year undergraduate course, including experimental and practical, but not applied, psychology. The research findings in various branches of psychology, child psychology, and abnormal psychology are

studied, as well as such related subjects as physiology and philosophy. Applied work at the undergraduate level is not favored as this should come after graduation. A distinction is made between the fields of educational, social, occupational, and abnormal psychology, and any one of them can be chosen for applied post-graduate work. For training in educational psychology, the field most closely applicable to pediatric work, students, under careful supervision, spend a further year working part-time in child guidance clinics and part-time in schools, where they learn at first hand of the many problems teachers must face in dealing with children who are backward or maladjusted. Experience is also gained of various types of educational institutes and clinics during this post-graduate year.

The Psychologist in the Children's Hospital.—Here the psychologist's work is concerned in the first place with investigations, where requested, into the intellectual abilities of the patient. The psychologist is trained to carry out various tests which remain constant and are standardized for different age levels. The results can be considered valid only when the psychologist interprets them in the light of the relationship existing between him and the patient at the time of the test. First he observes and records the child's behavior; then he interprets these observations in the terms of his own science, and evaluates them; finally he considers the findings in the light of their general significance for the further development of the child. However, the report at the end of the investigation is not considered complete unless it is related to the findings of other workers such as the psychiatrist and the social worker. It is one of the psychologist's important tasks to do this and he is called on to assist in the interpretation of the sum total of the findings in joint conference and consultation.

Secondly, the psychologist is expected to interpret these findings to outside workers such as teachers and play-group leaders.

Thirdly, certain children, when the major cause of their conflict is educational, need reëducation or remedial teaching. This is a form of therapy educational psychologists are trained to give.

Further, through the nature of their scientific training,

psychologists are equipped to advise on the design of experimental research which may be undertaken in a hospital.

Finally, the psychologist plays a part in the educational side of any teaching hospital in lecturing to undergraduates, graduates, and nurses, and in demonstrating his part in joint consultations and rounds.

The Psychiatric Social Worker.—The basic training of the social worker in the United Kingdom consists of a two-year course in the social sciences and social welfare work. If she wishes to become a medical social worker she must take a further year's training in hospital routines and procedures related to her work. To become a member of a psychiatric team she must enlarge her experience by further training in the psychiatric field, with both adults and children. This course extends over 12 months, leading to an additional certificate.

The chief function of the psychiatric social worker lies in the understanding of interperson relationships and in their interpretation to the members of the family. She does not give medical advice, nor does she administer psychotherapy unless specially trained.

Besides assisting through routine history-taking and case work, the psychiatric social worker is a valuable aid in emergencies, for when an acute behavior problem arises she is able to have a preliminary reassuring talk with the mother to assess the urgency of the problem, and to arrange accordingly for a consultation with the psychiatrist. Her rôle as an intermediary is to some extent illustrated in the following case.

Team-work in a Case of Ulcerative Colitis

This case was chosen to show how various members of the psychiatric team could combine to help the pediatrician to a fuller understanding of the child's and family's attitude to the illness, and what the child's potentialities were in terms of emotional and intellectual maturity.

The case

Derek first came to the pediatrician when he was 4½ years old. He had a chronic history of frequent bowel movements and of passing blood and mucus in his stools since an operation for fistula in ano when eight months old. Each succeeding year he had been in different hospitals and

it was with reluctance that he was admitted once more for diagnosis and treatment of his anemia.

As for all cases of ulcerative colitis in this ward, the child psychiatrist was asked to see him and, in his instance, to indicate how he would react emotionally at this stage to an operation for resection of his colon, should this be suggested.

The intervention of the psychiatric social worker

In the meantime the parents were seen by the pediatrician and invited to see the psychiatric social worker before their psychiatric consultation. The reason for introducing the psychiatric social worker at this stage was not to relieve the psychiatrist of his responsibility for taking a careful medical history or for making the diagnosis, but because the psychiatric social worker was so trained to take a history of the child's development, home surroundings, and family relationships that the time of the psychiatrist was saved, and the parents were passed through an educative process which eased the resistances they had and were thus prepared for his consultation. Up to this time Derek's parents had, in fact, had a lot of aggressive feeling against both doctors and nurses who, they felt, had done little to relieve the illness of their child. All this they were able to express to the psychiatric social worker. They gave an uneventful history of his early life, but were reserved about their family relationships; any pressure of questioning would inevitably have brought out unreliable information and was therefore avoided.

The psychiatrist's intervention

The psychiatrist saw Derek in the ward and, as a result of his findings, advised that if necessary the operation should be done forthwith. He found that the boy was immature, retarded in development, and constantly preoccupied with his bowel symptoms. The impression he obtained that Derek was inhibited and abnormally docile was confirmed when he talked with his mother. He prepared her for the operation which she accepted as one more act in the drama of this boy's illness, in which all the family were deeply involved.

Further surgical investigation showed, however, that an operation was not advisable at this stage and Derek improved sufficiently to be discharged and to continue at home with a low residue diet, vitamins, and iron. He proceeded to gain in weight and 18 months later was passing one normal bowel movement per day and doing well.

Meanwhile, when the mother had gained complete confidence in the doctors she gave the psychiatrist the true history of his illness. She had seen blood in his stools when he was only five months old and had anxiously rejected the idea, only to be consumed with guilt later as his illness progressed—an indication of the difficulty of obtaining an accurate history from an anxious parent.

The psychologist's part

Derek's mother had been resisting the idea of sending him to school and it was now some months after he should have started. This was the time at which the psychologist could help, and her opinion was sought as to his intelligence level, his social maturity, and his ability to cope with school life.

At the psychological department of the hospital he was given the revised Stanford Binet test, as this was the one most commonly used in schools for educational assessment. This test indicated that at the age of five years and seven months he had a mental age of four years. Owing to his anxious and inhibited nature and his fleeting attention only a modest share of his innate ability seemed available, but this certainly gave some idea of how much he would be likely to achieve at school. It indicated that school activities other than those of the nursery class would be beyond his comprehension, and this was conveyed to the teacher. He was also seen again by the hospital child psychiatrist, who found that he had been making good progress during the previous year until a few days prior to this visit, when his mother had been unwell with an axillary abcess. He had clung to her more than usual, refused his dinner, and significantly had an increase in the number of his stools to five or six a day. His mother now had sufficient insight and understanding to deal wisely with him over this.

Some weeks later blood was noticed again in his stools for the first time in many months, and, in spite of efforts to keep him out of hospital by giving him chemotherapy, he had to be readmitted. Under anesthetic he was found to have developed another fistula in ano. As an in-patient on this occasion he was able to mix better with other children, to talk of more than his bowel activities, and to enjoy and profit from the hospital lessons.

The psychologist took this opportunity to assess his social maturity which was compared with the Vineland Scale. This showed that his competence to care for himself and participate in social responsibilities was also on the four-year level. Although he was very young for such a procedure he was shown the Bellak Test pictures, to see whether he would produce any fantasy or indicate areas of anxiety.

The fantasy test indicated that parent figures were benign to him, and it was concluded from the whole of the psychological examination that there was natural subdued aggressiveness in him which he was inhibiting for fear of retribution. However, there were indications that he was not firmly arrested in his development, and was attempting to grow up. These findings confirmed and reinforced the clinical impression which had been gained.

In this case there was no doubt that his mother had at first been using too much pressure in controlling Derek, reducing his natural, spontaneous activities to a minimum. Deeper and more prolonged psychotherapy would have been worth trying, but was imposible to arrange owing to the distance of the home from the hospital or any child guidance clinic. On the other hand, as a result of the work of the psychiatric team the parents, although aware that the outcome was obscure, had changed remarkably in their attitude to the doctors and were far more coöperative in doing what they could for the boy.

Discussion.—In the course of the discussion it became clear that some pediatric centers were in the habit of consulting psychologists at the diagnostic stage, without calling in a child psychiatrist. Nearly all the members of the study group felt strongly that this practice was most inadvisable.

The training of a psychologist gives him no medical experience to fit him to work independently of a psychiatrist in a hospital. Instances were cited of pediatricians requesting psychologists with little or no knowledge of psycho-dynamic mechanisms to make diagnoses on the basis of tests which, though lengthy and time-consuming, were of little value since they were mechanically applied. The results were presented without proper interpretation, as though they were final and irrevocable as far as the individual child was concerned, much to the detriment of his treatment.

The question arises whether, apart from the reëducational therapy already mentioned, the psychologist or the psychiatric social worker should give orthodox psychoanalytical or other specialized forms of psychotherapy to children.

The issue is a controversial one, but there would seem to be no reason to debar them from this work provided two important conditions are fulfilled.

The first is that the psychotherapist should receive the necessary prolonged training in the specialized therapy techniques over and above the training already mentioned.

The second is that the therapy, in either case, be conducted under the direct supervision of a child psychiatrist, and in close association with the pediatrician in cases where physical complexities are likely to arise.

Essentially, the safeguard lies in coördination, the work being apportioned among the team to each as he is most competent to do it.

Conclusion.—If the various specialists and specialized workers concerned with the psychiatric examination and treatment work independently of each other the history and clinical findings are inevitably less comprehensive and may lead to treatment of a grossly inadequate nature.

Experience has shown that a comprehensive picture of the child's psychological and emotional state in his normal environment is best obtained through the close collaboration of psychiatrist, psychologist, and psychiatric or other specialized workers. Only so can an integrated diagnosis and satisfactory therapy be obtained and the pediatrician benefit most from the work of the psychiatric unit.

Annex 1

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BOOK REVIEWS

A Dictionary of Pastoral Psychology. By Vergilius Ferm and others. New York, Philosophical Library, 1955. 336 p.

Vergilius Ferm and his associates have made a contribution to the organization of thought in the borderlands of religion and science in the form of *A Dictionary of Pastoral Psychology*. This dictionary, an ambitious undertaking, represents a subject that could have been vastly amplified through the work of additional experts on the editorial board. However, the six collaborators have produced a reference handbook of semantic merit and of practical helpfulness to busy pastors and indeed to other readers, lay as well as professional. The dictionary contains not only definitions of basic words and phrases currently used in religion, psychology, psychiatry, and allied disciplines but also short expositions of major schools of thought in these areas together with paragraphs on mental mechanisms, special techniques, historical references, etc. The volume contains bibliographical material and a simple cross-index system. In some respects, this dictionary is an encyclopedia in miniature.

An initial effort to collect pertinent facts from the complexities of the fields represented is bound to have limitations. A protagonist of a given school of thought might feel dissatisfied with the emphasis on this or that aspect of the specific field. A busy man might find it disappointing to look for a definition of "spiritual" and to find "spiritual concern: see success" or "spiritual life: see saintliness; success." He might look for a definition of mental health and find "see health, mental." In turn, he would find "health, mental" means "see adult, the; autosuggestion; mental hygiene; psychology of religion, religion and mental health." To someone with a relish for psychiatric nomenclature, the term "mental disorders" lists a hodgepodge of terms (for further search) which might tickle his funny-bone or irritate him. It is to be hoped that in the revision of this dictionary the authors will make greater use of discourse immediately following the word or phrase under study, thus following more closely the more formal tradition of dictionary construction. Cross-reference is important but may occasionally become bothersome if not handled in a practical manner. Perhaps erudite readers might desire more bibliographical material but a general practitioner in theology would do well to take advantage of the present suggestions as to reading.

One special group of references exemplifies the vision and spirit that have gone into this dictionary. At first glance the discussions on pastoral psychology under various headings might lead to a con-

clusion that no human being could achieve the attributes described as being associated with the pastor in functioning both as a person and as a professional worker. Full reflection on the discussions, however, enlarges the significance of the pastoral role in today's society and cannot do otherwise than challenge the pastor to think and to inspire him to serve. This dictionary brings its own moments of inspiration to the reader.

EDWARD J. HUMPHREYS, M.D.

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SHOULD THE PATIENT KNOW THE TRUTH? A Response of Physicians, Nurses, Clergymen, and Lawyers. Edited by Samuel Standard, M.D., and Helmuth Nathan, M.D. New York, Springer Publishing Company, 1955. 160 p.

In schools of the health professions certain questions perennially arise that never seem to be settled. This is one of them: Should the patient be told he has a fatal illness? (Usually cancer is in mind.) In this book we have several different points of view, presented clearly, succinctly, and with conviction. Opinions range from discretion pending on the effect of the disclosure on the patient's condition and treatment to the out-and-out belief that the truth should always be told regardless of circumstances. Reasons for discretion are usually practical—on medical, legal, or religious grounds. Some patients do not want to be told and will not ask. Others will ask, but afterwards reproach the person who told them for doing so. Some will learn anyhow by inference or indirection. Cancer is by no means the only condition discussed; heart disease and neurological disorders come into account as well. *How* the patient should be told is brought out by some authors. It is heartening to see so little disagreement among such diverse authorities, particularly the representatives of different religions.

Unaccountably, social service workers are given no part in the symposium. Though they do not often have to discuss things with the patient, in our general and mental hospitals they usually have the task of telling the families what is wrong. This is at times more difficult than telling the patients. In fact, it is not uncommon, even in mental hospitals, to have the patient take unpleasant news better than anyone else concerned. We sometimes are treated to the scene of the patient comforting his relatives—and perhaps, occasionally, even the doctor! In a few places in this otherwise well-edited book misprints spoil smooth reading, most notably in this sentence from the Protestant clergyman: "Very often the dying patient . . . plays a part in the grizzly (sic) comedy of pretending."

This book should be useful to students and young practitioners in all those fields whose representatives come in contact with the seriously sick.

ROBERT A. CLARK, M.D.

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LIVING AND LEARNING IN NURSERY SCHOOL. By Marguerita Rudolph. New York, Harper Brothers, 1954. 170 p.

Marguerita Rudolph brings to the writing of *Living and Learning in Nursery School* the experience of fifteen years of nursery school teaching and teacher supervision in various well-known coöperative schools. It is obvious to the reader that the author has observed children closely and sympathetically and has thought critically of the part that the teacher can play in helping them with their living at school, as well as with the complicated process of integrating the many experiences that life affords them.

In the introduction, Jessie Stanton points up the need to help young teachers see more clearly what small children are like—"their deep dependence on adults, their peculiar ways of making friends, their worries and fears as well as their delights and joys; their limited understanding, their fresh ways of seeing the world, their need at times for firm control." She feels that this book of Marguerita Rudolph's can help because of its careful descriptions of the ways in which children behave.

The book, in my opinion also, is especially well suited for the use of young teachers. I can imagine its lending itself very well to classroom discussion. The material in it opens up easily these questions: What are young children like? How can the teacher help them? What kinds of experiences can be opened up for young children in nursery school? I can see the book being equally useful to parents who are seeking answers to the questions of, "Shall I send my child to nursery school? What can I hope that he will gain from it?" It should be useful, too, to that ever-widening group of mothers who are taking their turns on duty days in coöperative nursery schools across the country. The book should make what they see on these days at school more meaningful to them; it should help them to see more; it should make them critical in a more intelligent way of the program of their particular school.

In part one of the book, Mrs. Rudolph discusses the beginning of nursery school and its meaning to children. She points up the difficulties for young children in leaving their mothers and the rôle of the teacher in helping them. She describes the struggles of the children to make friends and the development of friendly contacts between

teacher and children. The reader is given a glimpse of various activities in the nursery school and of the children's delight in sharing them with one another and with their teacher.

Part two of the book describes the nursery school curriculum in action. Out of her experience with the United Nations International School in New York City, Mrs. Rudolph discusses concepts and practices of democracy in the nursery school and children's understanding of each other through their interests and activities. In this same section the rôle of the nursery school in helping children toward broader creative activity in the sphere of art is discussed. Mrs. Rudolph points up too the child's spontaneous interest in science and ways in which the teacher can help him with his questions.

In the final section, Mrs. Rudolph suggests evaluation of the children's growth. She describes their imaginative play and their trying out of the rôles of father and mother. She feels that the teacher should keep records of the children's growth and that these should include first impression reports, progress records, and reports to the parents.

"For a nursery school teacher there is always a challenge to understand children better and it also is pleasure to be in their company." On this note Mrs. Rudolph concludes her book with a discussion of the nursery school teacher. The nursery school teacher can keep on learning from the children and through discussions with her colleagues and with parents. The reader feels throughout Mrs. Rudolph's pleasure in being with children, and it is this spirit that gives the book real charm.

FRANCES P. SIMSARIAN

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THE CAUSES AND TREATMENT OF BACKWARDNESS. By Sir Cyril Burt. New York: Philosophical Library, 1953, 128 p.

The author's goal is to "survey what is already known and what has been accomplished, and then to summarize the main conclusions in a form available for the ordinary teacher. Thus, the immediate purpose of the book is practical rather than theoretical."

The text is, to some extent, an abridgement of a previous book (*The Backward Child*), and emphasizes that the treatment "of the dull and backward . . . must not only be sympathetic, but also scientific and, above all, based on a genuine understanding of the needs and aptitudes of each individual child."

The first two chapters deal with "The Problem and Its Origin," and "A Brief History of Child Study." They are well written and contain well-selected, quotable references to nineteenth century literary and philosophic opinions. Dr. Johnson declared that "stupidity is

commonly the result of stubbornness, and severity must be continued till negligence be cured. My master whipped me very well; without that, Sir, I should have done nothing," while Hobbes is quoted as saying, "The fool cannot be mended by flogging and he who flogs is a greater fool." When the national system of elementary education was introduced into Parliament in 1868, the notion of school for everyone was considered to be "a Utopian dream." Gladstone told Queen Victoria that he considered the author of the bill to be "a most impractical man." The Utilitarians considered "the low intellectual and moral condition of the masses" as a "secondary consequence of degraded conditions." James Mill stated that "if education cannot do everything, there is hardly anything it cannot do." But Carlyle argued that "everyday experience was sufficient to refute the new-fangled dogma of the equality of man."

The author describes the early experiences of Her Majesty's Inspectors (among whom was 'the apostle of culture,' Matthew Arnold), who examined pupils "to see how many failed to reach the 'standards' imposed by the Board's Code." The battle between the "hereditarians" ("once a defective, always a defective") and the "environmentalists" ("all that was needed was (sympathy and) a more adequate nourishment of both body and brain") must have been very bewildering to the average teacher. How classifications were developed, and how various grades of mental retardation were defined in terms of mental age, are clearly described. The author is one of the pioneers in the study and training of "backward" children. His first-hand account of the early attempts at child guidance in Great Britain and the history of the development of individual psychology are written with a personal appreciation of the great obstacles which stood in the way.

The book consists of eight chapters among which are, "The Methods of Investigation," "Environmental Factors," "Factors of Personality" (Physical, Intellectual, Emotional, and Moral Characteristics). The text contains many practical suggestions in regard to the handling of the mentally retarded child, and can be highly recommended.

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THE ONLY CHILD—A GUIDE FOR PARENTS. By Norma E. Cutts and Nicholas Moseley. New York: G. P. Putnams Sons, 1954. 245 p.

This book is written for all parents, but especially those who have only-children. Psychiatrists who are parents will want to read this book also. The book sets out to discuss the facts most likely to cause

trouble both in childhood and in later life, and suggests the practical steps to avoid dangers and build a healthy personality. In the United States, about one couple in six, of all those who ever have a child, has just one. About one child in twenty is an only-child. These figures are for absolute "Onlies." Of course, every oldest child is an only-child for a longer or shorter period. Other children in the family, when disparity of ages is great, may have the problems of an only-child.

"If a child is to fulfill his emotional need for group membership, he must have the satisfaction of knowing that he is accepted for himself and as himself by his peers. He must weather the storms that rise during free play among children: the persistent teasing, the brutal criticism, the fights, and the temporary exclusions. He must learn to compete for his due share of privileges and of honors. He must learn fortitude in the face of pain and disappointment, and endurance in the face of difficulties. He has to find out the values that children, like their elders attach to courage, initiative, and generosity. He has to learn to tolerate the idiosyncrasies of others. He has to be a good sport, eager to win but able to lose gracefully. He must learn to feel right about other people. The only-child is likely to be lacking in experience with other children, partly because he has no forced association with brothers and sisters, and partly because his parents get in his way. A few parents do this deliberately because they are afraid to let a child play with other children."

The authors have used the informal case method of interviewing parents of only-children and the children themselves. They have arrived at certain conclusions that are presented for the guidance of both the parents and the children.

This book is written in a clear, concise, intensely readable fashion that provides information in a most pleasurable way. It is recommended reading for any parent of an only-child, but all parents can profit from it.

WALTER E. BARTON

Boston, Mass.

NOTES AND COMMENTS

World Mental Health

World Mental Health is the quarterly publication of the World Federation for Mental Health. It is the mental health bridge between nations. Most of our psychiatric techniques—insulin, metrazol, electroshock and lobotomy, fever therapy, chlorpromazine and reserpine, antabuse, family care, Rorschach and Binet tests, and psychoanalysis have reached America from Europe by some such international bridge. *World Mental Health* costs but $1.00 per year. World Federation for Mental Health, 19 Manchester Street, London W. 1, England.

CBS Schedules Telecast on Mental Illness

The Columbia Broadcasting System will present a 90-minute television show on mental illness—called "Out of Darkness"—Sunday, March 18, from 5:00 to 6:30, prime time usually reserved for Omnibus.

Since CBS and the National Association for Mental Health are cooperating in publicizing the telecast, it is expected that a major portion of the nation will see the show. NAMH has undertaken the specific two-fold assignment of distributing—through state and local mental health associations and cooperating organizations—millions of leaflets announcing the telecast, and of arranging 100,000 televiewing parties in homes and public meeting rooms.

Mental health leaders predict that the telecast itself, plus the extensive advance publicity already set in motion, will give sharp impetus to community plans for the nation-wide Mental Health Campaign for NAMH members and funds during May and for local observances of Mental Health Week April 29 to May 5.

"The Value of Listening, Understanding, and Not Judging"

The doctor who is a sympathetic, trained listener will have the most success in patient treatment, it was stated by Dr. Lawrence C. Kolb, director of New York State's Psychiatric Institute, in a talk given at the North Shore Health Resort last March in Winnetka, Ill.

Discussing the "Value of Listening, Understanding, and Not Judging," Dr. Kolb declared these qualities are "prerequisite to all intensive psychotherapy. . . . These techniques alone are inadequate to resolve the problems of all those who come to the office of the physi-

cian, psychiatrist, or psychoanalyst, yet their skilled and judicious application offer one of the most effective means available for aiding the emotionally upset."

Dr. Kolb observed that both experienced and inexperienced practitioners tend to give less time to patients' stories and more to ordering various and sundry tests. He stated that "unfortunately this type of medical practice is still much in vogue, but there has been a growing appreciation of the fact that emotional illnesses may manifest themselves as organic defects. The growth of psychosomatic medicine has emphasized the need to listen, question, and evaluate the statements of the patient rather than accept simple answers to routine questions."

Listening, he explained, is a technical accomplishment of high order that does not arise from natural endowment alone, but is conditioned by our own experiences. "Doctors must recognize signs of upsetting anxiety and their intensity," said Dr. Kolb, charging that "some patients in diagnostic consultations might well have been spared psychotic breaks if over-eager young physicians had listened."

Legion Supports Mental Health

Urging greater citizen participation in the mental health movement, the American Legion's National Child Welfare Commission hammered a mental health plank into its Child Welfare Platform at a national meeting October 7–8 in Miami, Fla.

"We recognize the high incidence of mental illness and of serious emotional disturbances as the nation's primary health problem," the platform notes. "We approve steps now being taken by both government and voluntary agencies to increase research and the training of personnel.

"We urge greater citizen participation in the mental health movement.

"Although mental illness is a broad, complex, and little-explored area, we urge that present knowledge of treatment and prevention, limited though it may be, be put to more complete use."

In other planks, the Child Welfare Commission called attention to "a close relationship between broken homes and the problems of juvenile delinquency and mental health," suggested a critical review of marriage, divorce and related laws and of marriage counseling services, suggested that schools consider ways to aid in preparing young people for family living, and urged support for expanded research and services for mentally retarded children.

Dedicate New Wing for Astor Home

Termed "a shining example of what can be done with public money and private effort," a $175,000 wing of the Astor home for emotionally

disturbed boys at Rhinebeck, N. Y., was dedicated last fall by high dignitaries of church and state. Raymond Houston, New York's commissioner of social welfare, pointed out that the state welfare and mental health departments "needed the help of private agencies to find out what emotionally disturbed children were and what could be done for them." Dr. Harvey Tompkins, director of the Reiss Mental Health Pavilion at St. Vincent's Hospital in New York City, asserted the new facilities were "a signal advance in child psychiatry."

The new wing includes four classrooms, seven therapeutic offices, quarters for nurses and case workers, and conference and observation rooms with one-way windows for teaching purposes, as well as a small gymnasium, playrooms, lockers, showers, and storage space.

Francis Cardinal Spellman, archbishop of New York, blessed the new pavilion. The Astor Home is administered by the Daughters of Charity of St. Vincent de Paul.

Women Appointed to Research Posts

Named to "the first post of its kind ever established in the United States," Dr. Else Kris has joined the New York State Department of Mental Hygiene as research scientist in social psychiatry. In announcing her appointment, Dr. Paul Hoch, commissioner, pointed out that Dr. Kris has pioneered in combining psychiatry and sociology and is believed to be the only woman in the country to hold an M.A. in sociology as well as an M.D. In her new post Dr. Kris will conduct a comprehensive study of the social factors influencing the reintegration of mental patients after their release from institutions.

Dr. Lauretta Bender, of New York City, has been appointed principal research scientist in child psychiatry in the State Department of Mental Hygiene. The position was created under the department's new nine-point intensified treatment program which calls for greater emphasis on research in the emotional disorders of childhood and adolescence.

Dr. Bender will carry out research in the diagnosis, care, treatment, and follow through of mental illness, emotional disturbances, and antisocial or delinquent behavior in children and young adolescents in the state mental hospitals. Two wards at Creedmoor State Hospital, one for boys and the other for girls, will serve as the nucleus for this program.

Dr. Bender has been senior psychiatrist in charge of the Children's Service at Bellevue Hospital, New York City, for 21 years, and a member of the hospital staff since 1930. She will continue to serve as an attending psychiatrist on the children's service. She also will

continue as a professor of clinical psychiatry at the New York University-Bellevue Medical Center, a post she has held since 1951.

A well known research scientist, Dr. Bender has published over 100 papers on psychiatric studies of children conducted during her tenure at Bellevue. Last spring she received the Adolf Meyer Memorial Award for her multiple contributions to the understanding and treatment of schizophrenic children.

Provide Training in Child Psychiatry

Specialized training in child psychiatry is available in a number of member clinics of the American Association of Psychiatric Clinics for Children which have been approved as training centers. Training begins at the third-year, postgraduate level with minimum prerequisites of graduation from an approved medical school, an approved general or rotating internship, and a two-year residency in psychiatry, approved by the American Board of Psychiatry and Neurology. The majority of these clinics have also been approved individually by the American Board of Psychiatry and Neurology for a third year of training and for an additional year of experience.

This training is in preparation for specialization in child psychiatry, especially for positions in community clinics devoted wholly or in part to the out-patient treatment of children with psychiatric problems. At the completion of training, attractive openings are available in all parts of the country. Fellows receive instruction in therapeutic techniques with children in out-patient settings which utilize the integrated services of the psychiatric clinic team. Most of the clinics have a two-year training period although a few will consider giving one year of training in special cases.

Fellowship stipends are usually in line with U. S. Public Health Service standards—approximately $3,600. Stipends sometimes are paid by state departments of mental health and by individual clinics, and occasionally communities pay for the training of psychiatrists engaged to work in these communities at the end of their training. Special arrangements may be made occasionally to supplement the stipends by taking on other responsibilities locally (part-time work with the Veterans Administration, consultation to social agencies, etc.). A limited number of training centers offer higher stipends.

The office of the American Association of Psychiatric Clinics for Children acts as a clearing house for applicants. Application may be made through this office or directly to the individual clinics. In all cases, acceptance of applicants for training is by the individual training centers.

For further information and for application forms, write to Miss Marion A. Wagner, administrative assistant, American Association of Psychiatric Clinics for Children, 1790 Broadway, Room 916, New York 19, New York.

The Committee on Problems of Alcohol of the National Research Council annually makes grants for research projects, especially in biochemistry and physiology. Application forms may be secured from Jonathan O. Cole, M.D., National Research Council, 2101 Constitution Avenue, Washington 25, D. C.

Dr. Yakovlev Honored

The 1955 United Cerebral Palsy-Max Weinstein Award for outstanding scientific achievement in research on cerebral palsy has been awarded to Dr. Paul I. Yakovlev, clinical associate professor of neuropathology at Harvard Medical School. The award, which consists of a silver plaque and $1,000, was given to Dr. Yakovlev for his fundamental studies in the anatomy and physiology of the human brain. His research will serve, it is said, as a guide for understanding the causes and nature of cerebral palsy and may lead to direct therapeutic applications. He was recently appointed curator of the Warren Anatomical Museum at Harvard Medical School.

United States Observes Human Rights Day

By proclamation of President Dwight D. Eisenhower, Human Rights Day was observed in the United States on December 10, 1955. The celebration marked the seventh anniversary of the Universal Declaration of Human Rights, adopted without dissent by the UN on December 10, 1948.

In the words of its preamble, the Declaration raises "a common standard of achievement for all peoples and nations." The Declaration's moral impact has been reflected in 10 national constitutions, in judicial decisions, and in national legislation. President Eisenhower described it as "a significant beacon in the steady march towards achieving human rights and fundamental freedoms for all."

Human Rights Day is now observed by more than 80 nations.

Dr. Tompkins Heads Committee

Harvey J. Tompkins, M.D., of New York City, has been elected chairman of the professional advisory committee of the National Association for Mental Health. This group guides the organization on the psychiatric aspects of its program.

Publications of Interest

Starting with the January 1956 issue, *Sociometry,* the first journal of inter-personal relations, will be the official journal of the American Sociological Society. Founded by J. L. Moreno in 1937, it pioneered in introducing sociometry, group psychotherapy, rôle-playing, sociodrama, and psychodrama into scientific literature.

The New York Academy of Sciences has reprinted as a monograph the article, "Psychotherapy and Counseling," by Lawrence K. Frank, Rollo May and 46 other researchers, which appeared in Volume 63, pages 319–432, of the *Annals.* In this publication, investigators from five professions—medicine, psychology, social work, the ministry, and counseling and guidance—describe their techniques and results, emphasizing the need for cooperative efforts if satisfactory results are to be obtained. The monograph has 108 pages, is illustrated, and is available from the New York Academy of Sciences, 2 East 63rd Street, New York 21, N. Y., for $3.50.

In January 1956 the American Psychological Association will begin publishing a new monthly journal, *Contemporary Psychology: A Journal of Reviews.* Edwin G. Boring of Harvard University will edit the journal, with Adolph Manoil of Park College as film editor. Twenty-six consultants in the specialized fields of psychology will assist Dr. Boring.

Contemporary Psychology's aim is to provide critical reviews of books in the broad field of psychology and related sciences, thus providing comprehensive coverage of the psychological literature. Specialized book reviews formerly appearing in the APA journals *Psychological Bulletin, Journal of Applied Psychology, Journal of Abnormal and Social Psychology,* and *Journal of Consulting Psychology* will be concentrated in the new journal.

Subscriptions to *Contemporary Psychology* will be $8.00 a year, foreign subscriptions $8.50 a year, with single issues $1.00 each. Address correspondence regarding subscriptions to American Psychological Association, 1333 Sixteenth Street, N.W., Washington 6, D. C., and correspondence with the editor to Dr. E. G. Boring, Memorial Hall, Harvard University, Cambridge 38, Mass.

The last 10 years have seen a tremendous increase in the instrumentalities of international communication and collaboration. On the commercial side there is air travel; on the governmental side there are the UN agencies. On the side of citizen collaboration the World Federation for Mental Health is doing a remarkable job under the leadership of Dr. J. R. Rees. On the professional side, nursing,

psychiatry, psychoanalysis, child psychiatry, group therapy, etc., have their international gatherings.

The problems of publishing a national one-language journal are greatly magnified in the international effort. The International Institute for Research on Problems of Alcohol is therefore to be congratulated for its courage in launching the *International Journal of Alcohol and Alcoholism* under the joint editorship of E. M. Jellinek and H. Pullar-Strecker. It is to come out three times a year. The first number uses English, French, German, Spanish, and Italian. In addition to original articles presented in one of the five languages and summarized in the others, it publishes a classified bibliography of the current literature. The new journal is published in Oxford, England, by Blackwell Scientific Publications.

Significant Meetings

The American Orthopsychiatric Association will hold its 33rd annual meeting at the Hotels Commodore and Roosevelt in New York City, on March 15, 16, and 17, 1956. In more than 60 papers representatives of the wide range of professional disciplines and settings in orthopsychiatry will present orthopsychiatric theory and practice in five broad fields: schools and mental health; in-patient and out-patient psychiatric treatment of children; adolescence and juvenile delinquency; psychiatric clinic management; and adult psychotherapy.

The American Orthopsychiatric Association, founded in 1924, is composed of psychiatrists, psychologists, psychiatric social workers, and members of allied fields, including education, anthropology, and sociology. Members come from all parts of the United States, Canada, and abroad. Exie E. Welsch, M.D., New York, N. Y., is president, and Luther E. Woodward, Ph.D., New York, is president-elect.

Inquiries about the program, reservations, exhibits, and other details of the annual meeting should be directed to Dr. Marion F. Langer, American Orthopsychiatric Association, 1790 Broadway, New York 19, N. Y.

Yale Schedules Summer Studies of Alcoholism

The Yale Summer School of Alcohol Studies will hold its 14th annual session from July 1 to 26 inclusive. Applications must be submitted by April 15. Registration is open to teachers and school administrators, physicians, psychologists, clergymen and denominational workers, nurses, those in personnel work and in social and welfare work, public health, probation and parole, alcoholism education and therapy, law enforcement, and to other men and women

engaged professionally in activities in which a knowledge of the problems of alcohol would be helpful.

The curriculum is organized around a number of major topics: the origins, structure, and nature of social problems; theories in the development of personality; society and the problems of alcohol; drinking as a folkway; the chemistry and physiological action of alcohol: the psychological effects; theories concerning the nature and treatment of alcoholism and specific contemporary problems; and current activities and trends.

NAMH Holds Fifth Annual Meeting

More than 550 delegates from Mental Health Associations across the country attended the fifth annual meeting of the National Association for Mental Health in Indianapolis November 3 to 6, 1955. F. Barry Ryan, Jr., was reelected president, and Dr. Harold W. Elley was renamed chairman of the board of directors.

Dr. Marion E. Kenworthy was named first vice-president; Mrs. Henry Ittleson, second vice-president; Howard A. Wolf, first vice-chairman of the board; Charles Schlaifer, second vice-chairman; Henry C. Brunie, treasurer; Alan T. Schumacher, assistant treasurer; Brandon Barringer, secretary; and Richard P. Swigart, executive director.

In addition, five new officers were named: Frank C. Foose, Region I vice-president; Luther Alverson, Region II vice-president; Dr. Walter H. Baer, Region III vice-president; Mrs. Ernest R. Rector, Region IV vice-president; and Mrs. Mary Jeffries, Region V vice-president.

The committee on nation-wide activities and program development recommended that a chain of mental health information service centers be established by all Mental Health Associations. Their aim would be to help the mentally ill and their families locate the right place for treatment and help former patients with readjustment problems, and to serve as centers which would help local groups evaluate their community's mental health needs.

In a speech at the keynote luncheon Sidney Spector, director of the Interstate Clearing-House on Mental Health of the Council of State Governments, pointed out that state governments will have to do a greater and better job of caring for the mentally ill. At another session, three speakers discussed the respective roles of, and the necessity for cooperation among, the federal government, professional groups, and voluntary associations. They were Dr. Curtis Southard, chief of the Community Service Branch of the National Institute of Mental Health; David Slight, superintendent of mental health centers for the Illinois Department of Public Welfare; and Mr. Ryan.

At a luncheon meeting devoted to discussions of research Dr. John D. Benjamin, of the University of Colorado, described research methods and limiting factors; Dr. Elley reported on the kinds of research considered appropriate for NAMH; and Dr. George S. Stevenson, national and international consultant for NAMH, reported progress in the 17-project schizophrenia research program directed by the Supreme Council, 33°, Scottish Rite Freemasonry, Northern Masonic Jurisdiction, through the National Association for Mental Health.

At the annual banquet Governor George N. Craig of Indiana emphasized the importance of the mental health movement and of the unmet needs in the field. Though it is vital, he asserted, to serve well the needs of those in mental hospitals by giving them the best possible care and treatment, it is vital also to devote money and effort to research and training of personnel so that the mentally ill may be better served in the future.

Judge Luther W. Youngdahl of the U. S. District Court stressed the importance of the human element in efforts to help the mentally ill. In addition to the important physical requirements—good facilities, adequate treatment and care, and well-trained personnel—the mentally ill have great human needs that must be met, he said, if the sick are to achieve peace of mind, personal satisfaction, and a sense of worth. He stressed that respect for the individual is the keystone of a mental health program.

Panel discussions, workshops, and idea exchanges on fund-raising, public relations, and education, along with film previews and exhibits, rounded out the program.

APHA Forms Mental Health Section

At its 83rd annual meeting November 14 to 18, 1955, in Kansas City, Mo., the governing council of the American Public Health Association established a mental health section. Its officers are John D. Porterfield, M.D., chairman; Paul V. Lemkau, M.D., vice-chairman; and Rema Lapouse, M.D., secretary. The new section's council members include Dr. Ernest Gruenberg, Miss Ruth Simonson, Dr. Benjamin Passamanick, Miss Dorothea Dolan, and Dr. Morton Kramer.

The new section held two regular program sessions and a luncheon meeting addressed by Leonard M. Scheele, Surgeon General of the United States Public Health Service. Papers were presented on social drift of schizophrenia patients, the distribution of the elderly in the population, and their health and mental health problems. There were three papers on mental deficiency, one on its distribution in a county, one on the relationship between the hypothesis of foetal

wastage and mental deficiency, and a third on prematurity and its relationship to various neuropsychiatric conditions, including mental deficiency.

A full session of the public health nursing section of the APHA was devoted to a panel discussion of the role of the public health nurse in mental health.

The new section welcomes as members all who are interested in epidemiological and administrative problems in providing mental health services. Application blanks may be obtained from the American Public Health Association, 1790 Broadway, New York 19, N. Y.

Dr. Reginald M. Atwater, executive secretary of APHA said that discussions at the Kansas City meeting pointed up mental health and care of the chronically ill as major problems of the future which undoubtedly will be emphasized during the association's 84th annual meeting in Atlantic City, N. J., November 12 to 16, 1956.

Dr. Ira V. Hiscock, chairman of public health at Yale University, assumed the association's presidency at the close of the meeting. The new president-elect is Dr. John W. Knutson, chief of dental services of the U. S. Public Health Service and the first dentist to be elected to the position in the association's history.

Represent NAMH at International Conference

Mrs. Henry Ittleson, member of the board of the National Association for Mental Health and pioneer volunteer in the mental health field, and Dr. George S. Stevenson, national and international consultant to the National Association for Mental Health, attended the annual meeting of the World Federation for Mental Health in Istanbul, Turkey, August 21 to 30, 1955. The conference drew almost 250 delegates from 33 different countries, including about 60 from the United States.

With the theme, "Family Mental Health and the State," scientific papers emphasized mental health and education, the rearing of small children, abandoned children, life stress and cultural change, mental health of families in rural areas, delinquent children, the dynamics of family life, mental hygiene in the home, and problems created by sickness and disability. Discussion groups focused on education, religion, family relationships, medical practice, alcoholism, leadership, parent education, and films. Mrs. Ittleson presided at a session August 23 on the problems of abandoned children.

Dr. Margaret Mead and Dr. Otto Klineberg, both of the United States, were elected to the executive board, along with Dr. Cato Hambro, of Norway, and Irene Cheng, of Hong Kong. Dr. Niilo Maki, of Finland, is the Federation's new president; Dr. E. Eduardo

Krapf, of Argentina, is vice-president; Miss Mildred Scoville, of the United States, is treasurer; and Dr. Stevenson deputy treasurer.

The Federation will meet next in Berlin in mid-August 1956.

Record Attendance at Mental Hospital Institute

More than 400 attended the Seventh Mental Hospital Institute sponsored in Washington, D. C., October 3 to 6, 1955, by the American Psychiatric Association. Representatives came from all the 48 states and from Puerto Rico and Canada. About half were psychiatrists; 69 were hospital business administrators; and 89 came from other hospital disciplines and from related agencies.

In addition to holding eight work sessions, delegates visited St. Elizabeths Hospital, the clinical center of the National Institute of Mental Health at Bethesda, Md., and Chestnut Lodge, Rockville, Md., a private residential treatment center.

The theme was "Patient Participation in Treatment." Discussions focused on such topics as progressive responsibility and freedom for patients, staffing needs, and housing problems. The difficulty of obtaining sufficient mental hospital personnel and of providing them with adequate training was, delegates agreed, directly related to the matter of providing the conditions for patient-freedom. It was generally recognized that a hospital had the major burden for training its non-professional staff and that in-service training courses should be given a high priority.

The development of councils of patients, and the encouragement through them of self-government, seemed another means of moving toward freedom for patients and of providing an opportunity for the hospital staff and patients to work cooperatively on day-to-day problems met by both groups.

In discussing the contribution of the hospital's physical structure to the care of patients, Dr. Paul Haun, director of professional education for the Psychiatric Institute of the Pennsylvania Department of Welfare, asked: "May we agree that patient care, whether custodial or consciously therapeutic in aim, does not occur in a vacuum? And that between alternative physical environments we prefer for our patients the one which is safe, efficient, flexible, and attractive? May we also consider what contributions the physical structure of our hospitals can make to the efficiency, comfort, and self-esteem of our staffs?"

Dr. Jerome Frank of Johns Hopkins, Baltimore, lectured on group psychotherapy, and APA President R. Finley Gayle, Jr., spoke on the rôle of psychiatric units of general hospitals in the immediate care of the acutely ill.